CompcareBlue HMO Plan - Uniform Benefits
SCHEDULE OF BENEFITS

CITY OF MILWAUKEE - 11462-Management
Effective Date: January 1, 2004

Covered services are subject to the Deductibles, Copayments and Coinsurance as stated below. Unless otherwise noted, Covered Services are also subject to the Lifetime Maximum and Coinsurance maximum listed below. We never pay more than the Charge. For further details, please refer to the definition of Charge in Your benefit handbook.

Lifetime Maximum	$1,000,000 per Member
Deductible per Calendar Year	Individual: None Family: None
Coinsurance	None
Copayments	1. Emergency Room - $25 per visit (waived if admitted and PCP referred.) 2. Urgent Care - $25 per visit. Notes • Please refer to each section below for additional payment details.

Benefits	Copayment	Coinsurance	Benefit Maximums / Limitations / Notes
****Be sure to review Your benefit handbook for additional details about all the benefits listed below.**			
Allergy Testing and Treatment	None	None	
Ambulance Service	None	See notes	We pay 100% of the billed charge up to $300, and 80% of the billed charge per occurrence, thereafter. For air ambulance, We pay 100% of the billed charge up to $1,000, and 80% of the billed charge per occurrence, thereafter. Hospital to hospital transfers are paid at 100% of the billed charge.
Anesthesia	None	None	
Behavioral Health & Substance Abuse Inpatient Treatment	None	None	A Referral is not required, but Covered Services must be received from a Designated Provider. Covered Services are limited to 20 days per Member per Calendar Year. Thereafter, We pay 100% of one additional day for behavioral health treatment only.
Behavioral Health & Substance Abuse Outpatient Treatment	None	None	A Referral is not required, but Covered Services must be received from a Designated Provider. Covered Outpatient Services are limited to 25 visits per Member per Calendar Year. Thereafter, We pay 50% of an additional 27 visits per Member per Calendar Year for Outpatient and Transitional Treatment combined. Benefits are also available for Dependent students outside the Service Area. Please see the “What’s Covered?” chapter for details.

Benefits	Copayment	Coinsurance	Benefit Maximums / Limitations / Notes
****Be sure to review Your benefit handbook for additional details about all the benefits listed below.**			
Behavioral Health & Substance Abuse Transitional Treatment	None	None	A Referral is not required, but Covered Services must be received from a Designated Provider. Covered Services are limited to 20 visits paid at 100% per Member per Calendar Year. Thereafter, We pay 50% of an additional 27 visits per Member per Calendar Year for Outpatient and Transitional Treatment combined.
Childhood Immunizations	None	None	Benefits are available to Dependents for immunizations given from birth through age 18.
Chiropractor Services	See notes	See notes	A Referral is not required, but Covered Services must be received from a Designated Provider. If therapy services are provided, those services will be subject to the limits listed under "Therapy Services."
Dental Services	None	None	
Diabetic Equipment, Education & Supplies	None See notes	None See notes	Insulin infusion pump coverage is limited to one infusion pump per Calendar Year, provided You have used it for 30 days prior to purchasing it. Diabetic equipment, including insulin infusion pumps, is paid under “Durable Medical Equipment.” Diabetic supplies are paid under “Prescription Drugs.”
Diagnostic Services	None	None	
Durable Medical Equipment	None	See notes	A Referral is not required, but Covered Services must be received from a Designated Provider. You pay 20% Coinsurance up to a maximum of $500 per Member per Calendar Year for Durable Medical Equipment, Prosthetics, and Orthotics combined.
Emergency Care (Facility Charge for care received in the Emergency Room)	$25	None	The Copayment is waived if You are admitted to the Hospital directly from the emergency room or PCP referred.
Eye Exams	None	None	A Referral is not required, but Covered Services must be received from a Designated Provider. In addition to Medically Necessary eye exams, one routine exam for glasses is covered every Calendar Year.
Hearing Exams	None	None See notes	In addition to Medically Necessary exams, one screening audiometry examination is covered each Calendar Year. The screening audiometry exam is paid under “Preventive Care.”

Benefits	Copayment	Coinsurance	Benefit Maximums / Limitations / Notes
****Be sure to review Your benefit handbook for additional details about all the benefits listed below.**			
Home Care	None	None	A Referral is not required, but Covered Services must be received from a Designated Provider. Covered Services are limited to 50 visits per Calendar Year. Each Home Care Visit by a Physician or Other Practitioner that lasts up to four consecutive hours in any one 24-hour period will be counted as one visit. When provided in connection with hospice care, Covered Services will be subject to the limit listed under "Hospice Care," and not the 50 visit limit listed here.
Home Infusion Therapy	See notes	See notes	Equipment Charges related to home infusion therapy are paid under "Durable Medical Equipment" or "Diabetic Equipment," as appropriate. Home care Charges are paid under "Home Care."
Hospice Care	None	None	Covered Services are limited to six (6) months of treatment per Member per lifetime. We may, at Our discretion, extend this limit.
Hospital Services - Inpatient	None	None	
Hospital Services - Outpatient & Ambulatory Surgery Center Services	None	None	
Infertility Services	None	None	Covered Services are limited to determination and diagnosis.
Kidney Disease Benefits	None	None	Kidney transplants are subject to the $10,000 procurement limit per organ noted under "Organ Transplants."
Lead Poisoning Screening	See notes	See notes	Lead poisoning screening is paid as any other diagnostic service. Please refer to "Diagnostic Services" for details. Benefits are available to Dependents under six (6) years of age.
Mammography Exams	See notes	See notes	Mammograms are paid as any other diagnostic service. Please refer to "Diagnostic Services" for details. Yearly mammograms are available for Members age 40 and older. Any additional mammograms must be Medically Necessary.
Maternity Services	See notes	See notes	Prenatal care visits are paid under "Physician Services." Inpatient services related to maternity care are paid under "Hospital Services - Inpatient." Diagnostic services related to maternity care are paid under "Diagnostic Services."
Nurse Practitioner Services	See notes	See notes	Nurse practitioner services are paid under "Physician Services."
Oral Surgery	None	None	A Referral is not required, but Covered Services must be received from a Designated Provider.

Benefits	Copayment	Coinsurance	Benefit Maximums / Limitations / Notes
****Be sure to review Your benefit handbook for additional details about all the benefits listed below.**			
Organ Transplants	None	None	Preauthorization is required for transplants, other than kidney transplants. Benefits are also subject to a 365 day waiting period. Please see the "What's Covered?" chapter for details. Non-primary Procedures will be paid at 50%. Covered Services from an assistant surgeon will be paid at 25%. Covered Services from a Surgical Assistant will be paid at 15%. Transplants are limited to a $500,000 per Member per lifetime. Transplants are subject to a $10,000 procurement limit per organ.
Orthotics	None	See notes	A Referral is not required, but Covered Services must be received from a Designated Provider. You pay 20% Coinsurance up to a maximum of $500 per Member per Calendar Year for Durable Medical Equipment, Prosthetics, and Orthotics combined.
Physician Services	None	None	No Referral is required, but OB/GYN services must be obtained from a Network Provider to be covered.
Prescription Drugs	See notes	See notes	A 30 day supply per Prescription Order or refill is the maximum allowed. Preauthorization is required for certain Prescription Drugs. Please see the "What's Covered?" chapter for details. Prescription Drugs are subject to 20% Coinsurance up to a maximum of $1,000 per Member and/or family per Calendar Year.
Preventive Care	None	None	
Prosthetics	None	See notes	A Referral is not required, but Covered Services must be received from a Designated Provider. You pay 20% Coinsurance up to a maximum of $500 per Member per Calendar Year for Durable Medical Equipment, Prosthetics, and Orthotics combined.
Skilled Nursing Facility Services	None	None	Covered Services are limited to 120 days per Member benefit period. Benefit periods must be separated by at least 60 days without confinement. We will not pay less than the daily rate set for Skilled Nursing Facilities by the Wisconsin Department of Health and Family Services.
Surgery	None	None	Non-primary Procedures will be paid at 50%. Covered Services from an assistant surgeon will be paid at 25%. Covered Services from a Surgical Assistant will be paid at 15%.
Temporo-mandibular Disorder Treatment	See notes	See notes	Physician services related to the treatment of TMJ are paid under "Physician Services." Surgical and diagnostic services related to the treatment of TMJ are paid under "Surgery" or "Diagnostic Services." Nonsurgical and diagnostic services are limited to a combined maximum of $1,250 per Member, per Calendar Year.

Benefits	Copayment	Coinsurance	Benefit Maximums / Limitations / Notes
****Be sure to review Your benefit handbook for additional details about all the benefits listed below.**			
Therapy Services	None	None	Physical, occupational, and speech therapies are limited to a combined maximum of 50 visits per Member, per Calendar Year. A therapy visit is defined as up to one hour of therapy or three physical therapy modalities provided on any given day. Outpatient cardiac rehabilitation is limited to phase II only, for 3 one-hour sessions per week, for up to 12 consecutive weeks. Therapy services received as part of a home care plan will be subject to the limitations listed under "Home Care."
Urgent Care	$25	None	The Copayment is waived if You are admitted to the Hospital directly from the emergency room or PCP referred.

Amendment

Amendment

*****Important changes have been made to Your Plan.*****

Please review the information below regarding important updates to Your Plan. Be sure to keep this amendment with Your benefit handbook and review it carefully so You are able to make the most of Your benefits.

I. Schedule of Benefits

Our Designated Provider and Referral requirements have changed. This affects the following sections of Your Schedule of Benefits:

- Chiropractor Services,
- Durable Medical Equipment,
- Eye Exams,
- Home Care,
- Oral Surgery,
- Orthotics, and
- Prosthetics.

In these sections, the following note is deleted in its entirety:

A Referral is not required, but Covered Services must be received from a Designated Provider.

It is replaced with:

Covered Services must be received from a Designated Provider, if required by Your Provider network. Please refer to Your Provider Directory for details.

Please note that We no longer require the use of Designated Providers for Behavioral Health & Substance Abuse Services.

Under "Durable Medical Equipment," the following note is hereby deleted in its entirety:

You pay 20% Coinsurance up to a maximum of $500 per Member per Calendar Year for Durable Medical Equipment, Prosthetics, and Orthotics combined.

It is replaced with:

You pay 20% Coinsurance up to a Coinsurance maximum of $500 per Member per Calendar Year for Durable Medical Equipment, Prosthetics, and Orthotics combined.

Under "Physician Services," the following note is hereby deleted in its entirety:

No Referral is required, but OB/GYN services must be obtained from a Network Provider to be covered.

Under "Prescription Drugs" the current benefit is deleted in its entirety and replaced as follows:

Benefits	Copayment	Coinsurance	Benefit Maximums / Limitations / Notes
Prescription Drugs	See notes	See notes	A 30 day supply per Prescription Order or refill is the maximum allowed. Preauthorization is required for certain Prescription Drugs. Please see the "What's Covered?" chapter for details. Prescription Drugs are subject to a 20% Coinsurance up to a maximum of $1,000 per Member and/or family per Calendar Year.

Under "Therapy Services," the following note is hereby deleted in its entirety:

Physical, occupational, and speech therapies are limited to a combined maximum of 50 visits per Member, per Calendar Year. A therapy visit is defined as up to one hour of therapy or three physical therapy modalities provided on any given day.

It is replaced with:

Physical, occupational, and speech therapies are limited to a maximum of 50 visits per therapy per Member per Calendar Year. A therapy visit is defined as up to one hour of therapy or three physical therapy modalities provided on any given day.

II. Understanding Your Plan

As noted above in Your Schedule of Benefits, Our Designated Provider and Referral requirements have changed.

As a result, the following information in the section "What is an HMO Plan?" is hereby deleted in its entirety:

• **What is an HMO Plan?**	As a CompcareBlue HMO Member, You select a Primary Care Physician (PCP) when You Enroll. Your PCP will provide the majority of Your care and will arrange specialist care for You, if necessary.

It is replaced with:

• **What is an HMO Plan?**	As a CompcareBlue HMO Member, You select a Primary Care Physician (PCP) when You Enroll. Your PCP will provide the majority of Your care and can arrange specialist care for You, if necessary.

In the section "The Different Types of Providers," the definitions of Network Provider, Referral Provider, and Designated Provider have been revised.

The definition of Network Providers is hereby deleted in its entirety and replaced as follows:

• **The Different Types of Providers**	**Network Providers** Providers who have signed an agreement with Us to provide Covered Services to Our Members, usually at discounted rates.

The definition of Referral Providers is deleted in its entirety.

The definition of Designated Providers is hereby deleted in its entirety and replaced as follows:

• **The Different Types of Providers**	**Designated Providers** Many Medical Groups have a listing of Designated Providers for each of the following types of Covered Services: a. Chiropractors. b. Durable Medical Equipment. c. Home Health Care. d. Oral Surgery. e. Orthotics. f. Prosthetics. g. Routine Eye Exams.

You will need to use the Designated Providers listed under the same Medical Group as Your PCP in order to receive benefits.

Please note, however, that not all of Our Provider networks require use of Designated Providers. Please refer to Your Provider Directory for further information.

If You change Your PCP the Designated Providers available to You may change. Please be sure to check Your Provider Directory or call Customer Service to determine which Designated Providers You must use.

Please note that if You do not use the Designated Providers affiliated with Your PCP, Your benefits may be reduced or denied.

Your "Schedule of Benefits" will indicate when Designated Providers are required.

The section "Determining Which Providers You Are Required to Use" is hereby deleted in its entirety and replaced as follows:

- **Determining Which Providers You Are Required to Use**

Under Your CompcareBlue HMO Plan, all Covered Services must be provided by Your Primary Care Physician, a Network Provider, or a Designated Provider except:

- In the case of an emergency,
- If You have an approved written Referral from Your PCP to a non-Network Provider,
- If You are a Dependent student outside the Service Area that requires outpatient services for behavioral health or substance abuse treatment.

If You have questions about which services are covered or where or how to obtain those services, You may contact the Patient Coordinator within Your Medical Group. The Patient Coordinator is an invaluable resource who will help You make the most of Your CompcareBlue benefits. (In some Medical Groups, the person performing this service may have a title other than Patient Coordinator.)

The section "Referrals" is hereby deleted in its entirety and replaced as follows:

- **Referrals**

If, in the judgment of the Primary Care Physician, it would be in Your best interest to have services and/or supplies furnished by a Non-Network Provider, You may be eligible for a Referral.

Your PCP will select a Provider that meets Your needs, also taking into account any special arrangements We may have with Providers.

Referral. A valid Referral must:

1. Be made by the Member's PCP;
2. Be in writing;
3. Specify the Provider to whom the Referral has been made;
4. Be approved by Us;

5. Be obtained in advance of the provision of services and/or supplies by such other Provider; and
6. Specify the duration and/or extent of the Referral. If You feel Your medical condition requires that You be provided a Referral for an extended length of time, please discuss Your needs with Your PCP. Your PCP may provide You with a standing referral.

We recommend that You contact Us prior to receiving services if You are unsure whether the Referral has been approved.

If You change Your Primary Care Physician, Your new PCP must review and authorize any Referrals in effect in order for the Referral to remain valid.

Note: Approval of a Referral does not guarantee that all the services You receive from the Non-Network Provider will be covered. The services will still be subject to all terms of Your Plan, including Medical Necessity and Experimental / Investigational reviews, Benefit Maximums, Exclusions, and Eligibility requirements.

In the section "Urgent Care," the following statement is deleted in its entirety:

Urgent Care	Urgent care can also be provided at an urgent care Facility, if You have a Referral from Your PCP.

It is replaced with:

Urgent Care	Urgent care can also be provided at an urgent care Facility.

The section "Second Opinions" is hereby deleted in its entirety and replaced as follows:

Second Opinions	If Your Physician recommends a specific treatment or makes a diagnosis, You may obtain a second opinion from another Network Physician. The second opinion is usually for a consultation only.

III. What's Covered?

Under the "Behavioral Health & Substance Abuse Treatment Services" section of "What's Covered?" the first paragraph is deleted in its entirety and replaced as follows:

Behavioral Health & Substance Abuse Treatment	**Covered Services:** Benefits are available for Covered Services rendered by a Hospital, Physician, clinical psychologist, a psychologist certified by the American Board of Professional Psychology, a licensed clinical social worker (L.C.S.W), a licensed professional counselor (L.P.C.), a licensed marriage and family therapist (L.M.F.T.), or any other Provider to the extent described in this section.

The provision "Outpatient Services," listed under "Behavioral Health & Substance Abuse Treatment Services," has been revised to add the following to the list of Providers whose services may be considered as Covered Services:

• **Outpatient Services**	4. A licensed clinical social worker (L.C.S.W), a licensed marriage and family therapist (L.M.F.T.), or a licensed professional counselor (L.P.C.).

The "Dependent Student Benefit" under "Behavioral Health & Substance Abuse Treatment Services" has been revised to add the following to the list of Providers whose services may be considered as Covered Services:

• **Dependent Student Benefit**	3. A licensed clinical social worker (L.C.S.W), a licensed marriage and family therapist (L.M.F.T.), or a licensed professional counselor (L.P.C.).

The "Court-Ordered Services" provision of the "Behavioral Health & Substance Abuse Treatment Services" section is hereby deleted in its entirety and replaced as follows:

• **Court-Ordered Services**	Benefits are available for Medically Necessary Hospital services, Medical Services, and outpatient services for behavioral health or substance abuse treatment rendered to a Member pursuant to an emergency detention, an involuntary commitment, or a court order to the extent benefits would have been available under this Plan. Should such services not be rendered by a Network Provider, We will cover benefits to the extent that benefits would have been available when: 1. Services could not have been provided through a Provider selected by Us; and 2. The Provider or Member, or other person on behalf of the Member, notifies Us within seventy-two (72) hours of the initial provision of such services. Upon receipt of such notification, We will arrange for further Medically Necessary services to the furnished by a Network Provider. Reimbursement for services rendered by a Provider other than a Network Provider will be no more than the maximum reimbursement for the services under the state medical assistance program.

The following Exclusion, listed in the "Behavioral Health & Substance Abuse Treatment Services" section under "Services Not Covered" is hereby deleted in its entirety:

Behavioral Health & Substance Abuse Treatment Services	**Services Not Covered** • Treatment from a social worker, even if the social worker possesses the M.S.W. or C.I.C.S.W. credential.

In the "Physician Services" section, the following Exclusion listed under "Services Not Covered" is hereby deleted in its entirety:

Physician Services	**Services Not Covered** • Benefits for administrative examinations and their related services. This includes examinations performed for occupation or employment, purchase of insurance, and in preparation for litigation.

The following information in the "Prescription Drugs" section under "Preauthorization" is hereby deleted in its entirety:

• **Preauthorization**	You or the Pharmacy must contact the CompcareBlue Pharmacy to obtain Preauthorization. The telephone number and location of the CompcareBlue Pharmacy is included in the pharmacy directory.

Once approved, the Pharmacy will be authorized to dispense the medication. Future refills must be distributed by the CompcareBlue Pharmacy. Covered Prescription Drugs distributed by the CompcareBlue Pharmacy may be obtained in one of the following ways:

1. You may pick up the Prescription at the CompcareBlue Pharmacy, or
2. The medication may be mailed to You.

It is replaced with:

• **Preauthorization**	You or the Pharmacy must contact Us to obtain Preauthorization. Once approved, the Pharmacy will be authorized to dispense the medication.

IV. What's Not Covered?

The Exclusion "Court-Ordered Providers" is hereby deleted in its entirety and replaced as follows:

Court-Ordered Providers	Any service ordered by any court of law unless the service is Medically Necessary and provided by a Network Provider.

The Exclusion "Non-Network Providers" is also hereby deleted in its entirety and replaced as follows:

Non-Network Providers	Services, supplies, or equipment rendered by a Non-Network Provider, except: 1. Services provided in an emergency; 2. Outpatient behavioral health and substance services provided to a student who is outside the Service Area.

The following item is hereby deleted from the "Providers" Exclusion:

Providers	e. Social worker;

The following Exclusion is hereby added.

35. Breast Reduction Surgery - Breast Reduction surgery is not a Covered Service.

V. General Legal Provisions

In the "General Legal Provisions" chapter, the following information under "The External Review Process" is hereby deleted in its entirety:

• **The External Review Process**	In either case, the treatment must cost more than $250 in order to qualify for External Review.

It is replaced with:

• **The External Review Process**	In either case, the treatment must cost more than the minimum amount specified annually by the Wisconsin Commissioner of Insurance in order to qualify for External Review. (In 2004 the minimum amount was $250.)

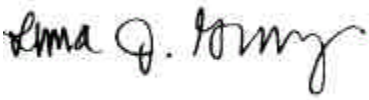
VI. Glossary

In the "Glossary," the definition of CompcareBlue Pharmacy is hereby deleted in its entirety and replaced as follows:

CompcareBlue Pharmacy	PrecisionRx, a mail-order pharmacy that can be reached at 1-800-293-2202 or www.precisionrx.com.

This Amendment is Hereby Made Part of Your Compcare Health Services Insurance Corporation (CompcareBlue) Plan

Effective Date: January 1, 2005



Rebecca A. Kapustay, President & CEO

Lorna J. Granger, Assistant Secretary

CITY OF MILWAUKEE
11462-Management
HMO Plan - Uniform Benefits
Effective Date: January 1, 2004

Important Notice Regarding Payment of Covered Services

Your health insurance Plan limits benefits for Covered Services to the allowable Charge, as defined in the "Glossary" at the back of this Benefit Handbook. The allowable Charge may be less than the amount billed by Your Provider. Please see page 62 in the "General Legal Provisions" chapter for information on how to determine what We will cover as the Charge.

Important Notice Regarding Statements In The Enrollment Form For Your Insurance

Please review the copy of the enrollment form you completed when applying for coverage. Omissions or misstatements in the enrollment form could cause an otherwise valid claim to be denied. Carefully check the enrollment form and write to Us within ten (10) days if any information in the form is incorrect or if any information is missing.

Contact Information

Any time You have a question or request, please do not hesitate to call, e-mail or write to Us at:

Compcare Health Services Insurance Corporation (CompcareBlue)

P.O. Box 2270

Fond du Lac, Wisconsin 54936

CUSTOMER SERVICE DEPARTMENT

1-888-239-9514

bluecrosswisconsin.com

For behavioral health or substance abuse services, contact APS Healthcare at 1-800-989-2792.

For information in a language other than English, call Us at 1-888-239-9514.

If You wish to file a Grievance, please send it to the following address:

Compcare Health Services Insurance Corporation (CompcareBlue)

P. O. Box 641

Attn: Grievance Department

Milwaukee, Wisconsin 53201-2947

Table of Contents

Welcome

Welcome to CompcareBlue

We are pleased that You have become a Member of Our health insurance Plan. In addition to providing You with outstanding coverage, We want to ensure that Our services are both easy to understand and easy to use. We've designed this Benefit Handbook to provide clear and concise explanations of Your Plan's policies and procedures, along with step-by-step guidelines for maximizing the benefits available to You.

This handbook, Your "Schedule of Benefits," and any riders and/or amendments are all part of Your CompcareBlue Plan, which is a legal document. Please carefully review all information contained in these materials. Also refer to the Member Guide booklet for helpful explanations of common insurance concepts and terms.

How to Use this Benefit Handbook

The format of this handbook was created based on recommendations from the experts -- our valued Members. For quick, easy access to the information You need, use the following tools as Your guide.

- **Capitalized Words & Glossary** You may have already noticed that many words are capitalized. Most capitalizations indicate terms that are defined in the "Glossary" at the back of this handbook. Please note that the words We, Us and Our refer to CompcareBlue. You and Your refer to the people who are covered under Your Plan.
- **Index** Many topics are inter-related and appear in more than one chapter or section. Use the Index for immediate location of all pertinent information.

Medical Necessity

One of the primary principles of health insurance is Medical Necessity -- a term that appears often on the following pages. To qualify for benefits, a service must meet our standards for Medical Necessity, which We determine based on the findings of a special utilization review process and generally accepted medical practice. For a more thorough explanation, see the discussion of "Medical Necessity –What Is It?" in the chapter "Understanding Your Plan."

Respecting and Protecting Your Privacy

As a CompcareBlue Member, You have agreed to provide Us with information regarding Your health, including medical records. We agree to keep all information confidential and use it only as set forth in Our Privacy Practices Notice, which can be found on our website at **bluecrosswisconsin.com**.

How to Contact Us

If You have questions or requests, please do not hesitate to contact Us. Our Customer Service Representatives are more than happy to help. We encourage you to visit us online at **bluecrosswisconsin.com,** or call or write to the office listed on the first page of this handbook.

Health insurance doesn't have to be complicated. At CompcareBlue, We're doing everything We can to simplify the process. We look forward to serving You.

Understanding Your Plan

What are the main features of Your health insurance Plan? How does it work? What's required to ensure You get the most benefits from this important coverage?

This chapter contains valuable details about Your Plan ? how to locate Providers, how Medical Necessity affects You and key insurance concepts. You will also learn about Precertification and Preauthorization, and much more.

What Is an HMO Plan?

The CompcareBlue Health Maintenance Organization (HMO) Plan is a product of Compcare Health Services Insurance Corporation. We have designed this Plan to provide benefits to You when You are healthy as well as sick. The Plan provides a comprehensive package of health care benefits, including preventive services such as Office Visits, physical exams and immunizations.

As a CompcareBlue HMO Member, You select a Primary Care Physician (PCP) when You Enroll. Your PCP will provide the majority of Your care and will arrange specialist care for You, if necessary.

- **The Different Types of Providers**

Throughout this handbook and in Your "Schedule of Benefits" You will see references to several types of Providers. To help You understand the differences between these Providers, We have defined these terms below.

Primary Care Physician A Network Provider You select at Enrollment to coordinate all of Your health care services. The following types of Physicians can be designated as Primary Care Physicians:

a. Family Practice - treat medical conditions for people of all ages, with an emphasis on family health problems.
b. General Practice - treat people of all ages.
c. Internal Medicine - treat diseases and disorders of both adult men and women.
d. Pediatric Medicine - treat children.
e. Geriatric Medicine - treat elderly people.
f. Adolescent Medicine - treat adolescents.

Network Providers Providers who have signed an agreement with Us to provide Covered Services to Our Members, usually at discounted rates. In most cases, You will need a Referral to see a Network Provider other than Your PCP.

Referral Providers Providers to whom You have been given an approved Referral. They are usually Network Providers, but can be non-Network Providers if We approve the Referral.

Designated Providers Network Providers who You do *not* need a Referral to see, but who You must see in order to receive benefits. Designated Providers are required for the following Covered Services:

a. Behavioral Health and Substance Abuse.
b. Durable Medical Equipment.
c. Home Health Care.
d. Oral Surgery.
e. Orthotics.
f. Prosthetics.
g. Routine Eye Exams.

Your "Schedule of Benefits" will indicate when Designated Providers are required.

Non-Network Providers Providers that do not belong to Our Network. We also refer to them as out-of-network Providers. In most cases, no benefits are available when You receive services from a non-Network Provider.

Medical Group The clinics and IPAs which provide Medical Services to Members. A clinic is a group of Physicians who work together in a multi-specialty Facility; an IPA is a group of associated Physicians who maintain their individual practices. When You join CompcareBlue, You are asked to sign up for one clinic or IPA.

Please note that all Providers who are part of Our network are listed in Our Provider Directory. You can obtain an online version of the directory at **bluecrosswisconsin.com**, or call one of Our Customer Service Representatives to request a printed copy, free of charge.

- **Determining Which Providers You Are Required to Use**

Under Your CompcareBlue HMO Plan, all Covered Services must be provided or directed by Your Primary Care Physician, except:

- In the case of an emergency,
- If You have a written Referral from Your PCP to an approved Referral Provider,
- If You see a Designated Provider.
- If You are a Dependent student outside the Service Area that requires outpatient services for behavioral health or substance abuse treatment, or
- If You are a female Member and see a Network obstetrician/gynecologist (OB/GYN).

If You have questions about which services are covered or where or how to obtain those services, You may contact the Patient Coordinator within Your Medical Group. The Patient Coordinator is an invaluable resource who will help You make the most of Your CompcareBlue benefits. (In some Medical Groups, the person performing this service may have a title other than Patient Coordinator.)

- **Enrolling in CompcareBlue HMO**

As previously mentioned, when Enrolling, You and Your Dependents must select a Medical Group and then a Primary Care Physician (PCP) from that Medical Group. Because each family member has individual needs, You may choose a different PCP for each person. Remember, all Primary Care Physicians must be part of Our network.

Women who Enroll may also select an in-network OB/GYN.

The PCP is responsible for Your total health care ? ?from directing routine preventive procedures to coordinating more serious medical treatments. Always think of Your PCP as the primary point of contact for all Your health care needs.

- **Changing Your Primary Care Physician or Medical Group**

It is important to develop a good relationship with Your PCP. His or her knowledge of You as an individual will add to the effectiveness of Your treatment.

If You find You are unable to develop a positive relationship, You may wish to consider changing Physicians. You may change Your Medical Group selection annually at Open Enrollment or within thirty (30) days of an address change. You may change PCPs within Your Medical Group a maximum of three (3) times per year. The change will be effective no earlier than the first of the month following Our receipt of Your request. The Patient Coordinator at the Medical Group will be able to assist You in Your selection of a new PCP.

If You decide to change Your Medical Group while covered under this Plan, the Designated Providers available to You may change. Be sure to review Our Provider Directory for a list of those associated with Your new Medical Group. If You choose to continue to see the Designated Providers You have been using, benefits may be reduced or denied.

Any time You make a change, contact Our Customer Service Department. We'll update Your information and send You new insurance identification (ID) cards that reflect the new PCP's name.

Referrals

If, in the judgment of the Primary Care Physician, it would be in Your best interest to have services and/or supplies furnished by a Provider other than Your PCP, You may be eligible for a Referral.

Your PCP will select a Provider that meets Your needs, also taking into account any special arrangements We may have with Providers.

- **Definition**

Referral A valid Referral must:

1. Be made by the Member's PCP;
2. Be in writing;
3. Specify the Provider to whom the Referral has been made;
4. Be approved by Us if the Referral is made to a non-Network Provider;
5. Be obtained in advance of the provision of services and/or supplies by such other Provider; and
6. Specify the duration and/or extent of the Referral. If You feel Your medical condition requires that You be provided a Referral for an extended length of time, please discuss Your needs with Your PCP. Your PCP may provide You with a standing referral.

We recommend that You contact Us prior to receiving services if You are unsure whether the Referral has been approved.

If You change Your Primary Care Physician, Your new PCP must review and authorize any Referrals in effect in order for the Referral to remain valid.

Note: Approval of a Referral does not guarantee that all the services You receive from the Referral Provider will be covered. The services will still be subject to all terms of Your Plan, including Medical Necessity and Experimental / Investigational reviews, Benefit Maximums, Exclusions, and Eligibility requirements.

Precertification

Throughout this handbook and Your "Schedule of Benefits," You will see several references to the term Precertification. We have defined this term as follows:

- **Definition**

Precertification The process You must follow when You are to be admitted as an Inpatient to determine if benefits are available for Your Hospital stay. This applies to both unexpected emergency admissions and scheduled Hospital stays.

Your Primary Care Physician should handle the Precertification for You.

- **48 Hours' Notice**

You or Your Primary Care Physician must contact Us *within* forty-eight (48) hours of an emergency admission or forty-eight (48) hours *in advance* of a scheduled admission. The number to call for Precertification appears on the back of Your ID card and on the first page of this handbook.

Always check with Us prior to an elective or planned Inpatient Hospital admission to make sure Your Precertification has been completed.

Please carefully review the "Precertification Program" chapter in this handbook for further explanation of this important process.

Preauthorization

In addition to Precertification of Hospital stays, We also require Preauthorization of certain services and supplies. When You see the term Preauthorization used throughout this handbook, it has the following meaning:

- **Definition**

Preauthorization The process of determining whether benefits are available for specific services or supplies. Examples include, but are not limited to:

a. Pharmaceuticals.
b. Durable Medical Equipment.
c. Therapy.
d. Transplants.

You should contact Customer Service to determine whether Covered Services require Preauthorization.

Your PCP should handle any Preauthorization of benefits that is needed for care that he or she provides. However, You should always check with Customer Service if You are unsure about the status of a Preauthorization request.

Please note that if Preauthorization is required and not obtained, benefits may be reduced or denied.

Emergency Situations

Your CompcareBlue Plan provides coverage for emergency care twenty-four (24) hours a day, seven days a week. In the event of a life-threatening emergency, seek medical care immediately at the nearest emergency room Facility or call 9-1-1.

Urgent Care

In urgent but non life-threatening situations – such as worsening sore throats, sprains, cuts, cuts with controlled bleeding, minor bone fractures, and infections – You should immediately contact Your PCP for instructions on how to get appropriate medical attention.

Urgent care can often be provided at Your PCP's office. Many offices are open evenings and weekends to handle "off hour" problems. Urgent care can also be provided at an urgent care Facility, if You have a Referral from Your PCP.

Important Information about CompcareBlue Providers

We have contracted with health care Providers and health care Facilities that have agreed to provide Our Members with Medical Services. The health care professionals are not employees, agents or representatives of Ours. We do not have an ownership interest in any medical Facility, other than Our own CompcareBlue Pharmacy, at this time.

Your health care Provider is solely responsible for all decisions regarding Your care and treatment, regardless of whether such care and treatment is a Covered Service under Your Plan. Under their contract with Us, the health care professionals and health care Facilities may receive financial incentives to provide Covered Services in the most cost-efficient manner consistent with sound medical practice and without compromising the patient's health.

Continuity of Care

If Your Primary Care Physician or another Network Provider who has provided Covered Services to You terminates his or her agreement with Us, please contact Our Customer Service Department. We have procedures in place that will allow You to continue to see that Provider for a limited time. We can also assist You in selecting another PCP or Network Provider to provide Your care.

Claims Payment

When determining how claims should be paid, We use a variety of methods.

- If We have a contract with a Provider, We often have a negotiated fee schedule which specifies the pre-determined amount We will pay for certain claims.
- Sometimes We pay contracted Providers by capitation, which is another form of a negotiated fee.
- Other times We simply pay a percentage of the Usual, Customary and Reasonable Amount (UCR). UCR generally involves comparing what other Providers charge for the same service to determine the appropriate amount for claims payment.

It is important to note that the amount the Provider bills Us is not always the amount We pay.

If You use a Provider who has a contract with Us to provide services under Our Plan, You should not be charged for the difference between the amounts We pay and the amounts the Provider bills. However, You would be expected to pay any Deductibles, Coinsurance, Copayments, and charges for non-Covered Services that apply.

On the other hand, if You chose to use a Provider that does not have a contract with Us, You may be responsible for the portion of that Provider's bill that is in excess of what We pay as the Charge.

Medical Necessity – What Is It?

Medical Necessity is an important term used by most insurance companies, including Us, to describe the process of evaluating whether recommended services, supplies or equipment are necessary to treat a condition. The fact that a doctor recommends a service or treatment does not automatically mean it is considered Medically Necessary under this insurance Plan.

If We determine, according to Our policies and procedures, that the recommended service is not Medically Necessary, it will not be covered. Please refer to the "Glossary" for more information on how We evaluate Medical Necessity.

Experimental / Investigational

Another common term used by many insurance companies is Experimental / Investigational. This generally refers to treatments that have not yet been proven effective and, as a result, are not eligible for coverage under Your Plan. A detailed description of how We evaluate whether a treatment is Experimental / Investigational can be found in the "Glossary."

Second Opinions

If Your Physician recommends a specific treatment or makes a diagnosis, You may obtain a second opinion from another Physician. You will be referred to a Physician who has been authorized by Your Medical Group. The second opinion is usually for a consultation only.

Identification Cards

When Your coverage begins, We will give You identification cards that contain the following information:

- Your Subscriber and Group numbers.
- The names of any Members insured under Your Plan.
- A Customer Service telephone number.
- Claims instructions for Providers.

Show this card whenever You obtain services. It will assist Your Provider's office in submitting claims. If You lose an ID card, call Our Customer Service Department to request another.

Scheduling & Cancelling Appointments

When You wish to see Your Physician or need medical treatment, call the Physician's office to make an appointment. The phone number is listed in Our Provider Directory. Remember, Your telephone is the key to good service ? **always call first**.

If You must cancel an appointment, please call Your Physician at least twenty-four (24) hours in advance or as soon as possible. We do not cover Charges for failure to keep an appointment.

Coverage Changes

In the event You need to change Your coverage as a result of a birth, adoption, marriage, divorce, separation, death, marriage of dependents, change in address, or military induction, contact Your employer to obtain the appropriate change notice form.

The BlueCard Program

Like all Blue Cross & Blue Shield plans throughout the country, We participate in a program called “BlueCard.” This program allows You to receive Covered Services when You are traveling out of state and need emergency or urgent medical care, as long as You use a BlueCard Provider. All You have to do is present Your identification card to a participating Blue Cross & Blue Shield Provider, and they will submit Your claims to Us.

If You are out of state and an emergency or urgent situation arises, You should receive treatment right away. You should then contact Your Primary Care Physician as soon as possible to arrange for any follow-up treatment when You return home.

To find the nearest contracted Provider, You can visit the BlueCard Doctor and Hospital Finder website (www.BCBS.com) or call Bluecard Access at 1-800-810-BLUE.

You can also access doctors and hospitals outside of the U.S. The BlueCard program is recognized in more than 200 countries throughout the world.

Contact Us for Help at Any Time

Questions? Requests? Comments? Any time You wish to speak with Our staff about Your health insurance coverage, please do not hesitate to call or write Us. Our knowledgeable Customer Service Representatives look forward to helping You maximize the benefits of Your CompcareBlue health insurance Plan.

Also be sure to visit Us at Our website at **bluecrosswisconsin.com**. There You’ll find easy access to the following:

- A complete "Provider Directory," updated weekly.
- Claim updates.
- Prescription Drug information.
- Forms for claims, application and other needs.
- And much more.

Thank You for choosing Us as Your health insurance partner.

Please Read This Handbook Carefully Before Receiving Medical Care.

Eligibility Guidelines

In this chapter, You will find information on who is Eligible for coverage under this Plan, guidelines for submitting an application, situations in which Eligibility may be lost, Medicare considerations, conditions for individual reinstatement, and more.

Whether You have already submitted an application or are planning to submit one soon for either Yourself or a Dependent, be sure to read this chapter carefully. It outlines important deadlines that must be met during the application process, and also provides useful information on when coverage will become effective after submitting an application. Please note that if You miss the application deadline, Your coverage Effective Date will be delayed.

In the event either You or a Dependent loses Eligibility, be sure to refer to the "Termination of Coverage" chapter for details on possible continuation rights that may be available.

Definitions

To fully understand Our Eligibility guidelines, You will need a basic understanding of the following terms. Please read through these definitions and refer to them often as You continue through this chapter.

Eligible (Eligibility) You and/or Your Dependents qualify for, and can be covered under Our Plan. Certain requirements must be met to maintain Eligibility.

Effective Date The date on which Your and/or Your Dependents' coverage under this Plan begins.

Enroll (Enrollment) The application process where You submit a completed application to Us and We begin coverage of You and/or Your Dependents under this Plan.

Initial Eligibility The first date that You and Your Dependents are Eligible to apply for coverage.

Open Enrollment The period or periods of time set up by Us and the Group during which You may apply for coverage for Yourself and Your Dependents.

Probationary Period The continuous length of time that You must be employed with the Group before You and Your Dependents are Eligible for coverage under this Plan. The Probationary Period is shown in the Group application.

You / Your In this section only, the words You and Your refer only to the Subscriber (i.e., the employee).

Subscriber Eligibility

To be Eligible for coverage, You must be a regular, permanent employee (not substitute or temporary), a partner, or sole proprietor. You must also:

1. Actively perform the duties of Your principal occupation for the Group (i.e., be Actively at Work) at least twenty-one (21) hours per week;
2. Satisfy any Probationary Period that applies to You; and
3. Be Eligible for all the fringe benefits that apply to the class of employees to which You belong.

Dependent Eligibility

Dependents who are Eligible for coverage include:

1. Your legal spouse;
2. Your or Your insured spouse's unmarried children who are unable to provide their own support. This includes legally adopted children, and children for whom You or Your insured spouse is the legal guardian; and
3. Your Dependent child's children (i.e., Your grandchildren) until Your Dependent child reaches age eighteen (18).

When Subscribers Can Apply Coverage

When applying for insurance, You must submit an application during one of the application periods listed below. To ensure that Your coverage begins on the Effective Date described, We must receive the completed application from You by the deadline -- which is generally within thirty-one (31) days of the event.

The earlier You submit the completed application to Us, the better.

If We do not receive Your completed application within the specified period, Your ability to obtain coverage under this Plan will be delayed.

For example, if Your Initial Eligibility date is May 1st, but We don't receive Your completed application until June 1st, We would not be able to Enroll You as of May 1st. You would have to wait until the next Open Enrollment period -- unless You experience another one of the other events listed below -- and notify Us at the appropriate time.

Application Periods for Subscribers

Below are the application periods within which You can apply for coverage, along with an explanation of when Your coverage will begin:

1. **Within thirty-one (31) days of Initial Eligibility.**

   Your Effective Date will be the first of the month following the date You complete any Probationary Period required by the Group, provided We receive the completed application before the end of the thirty-one (31) day period.

2. **Within thirty-one (31) days of termination or exhaustion of other coverage.**

   Your Effective Date will be the first of the month following Our receipt of the completed application, provided We receive the completed application before the end of the thirty-one (31) day period.

3. **Within thirty-one (31) days of marriage, birth of a child or placement for adoption.**

   Your Effective Date will be the date of a marriage, birth or placement for adoption, provided We receive the completed application before the end of the thirty-one (31) day period.

4. **Within thirty-one (31) days of an election event described in the Group's Section 125 cafeteria plan.**

   A cafeteria plan, which is maintained by the Group, often provides additional periods in which You can apply for coverage. The Group will notify Us if its cafeteria plan has these additional application periods. We must review and approve those periods before Enrolling You in this Plan. Please contact the Group with any questions.

   If We approve the election event, Your Effective Date will be the first of the month following Our receipt of the completed application, provided We receive it within thirty-one (31) days of the event.

5. **During Open Enrollment.**

   Your Effective Date will be the first day following the date agreed upon by Us and the Group, provided We receive the completed application before the end of the Open Enrollment period. The Group will notify You when Open Enrollment is available.

When to Apply for Dependent Coverage

If You would like to apply for coverage for Your Dependents, You must also meet specific application period deadlines.

If We do not receive the completed application within the specified period, Your ability to obtain coverage for Your Dependents will be delayed.

Application Periods for Dependent

Below are the application periods within which You can apply for coverage for Your Dependents, along with an explanation of when coverage will begin:

1. **Within thirty-one (31) days of Your Initial Eligibility.**

   Your Dependent's Effective Date will be the first of month following the date You complete any Probationary Period required by the Group, provided We receive the completed application before the end of the thirty-one (31) day period.

2. **Within thirty-one (31) days of termination or exhaustion of other coverage.**

   Your Dependent's Effective Date will be the first of the month following Our receipt of the completed application, provided We receive the completed application before the end of the thirty-one (31) day period.

3. **Within thirty-one (31) days of the Subscriber's marriage.**

   Your Dependent's Effective Date will be the date of the marriage, provided We receive the completed application before the end of the thirty-one (31) day period.

4. **Following the birth of a Dependent.**

   If Family Coverage is not already in force, Your Dependent's Effective Date will be the date of birth, if You send Us the completed change form within thirty-one (31) days of the birth.

   If Family Coverage is already in force, Your Dependent's Effective Date will be the date of birth. If, however, additional premium is required for the newborn Dependent, Your Dependent's Effective Date will be the date of birth only if:

   - You notify Us of the birth and pay the additional premium within sixty (60) days of the birth, or
   - You notify Us within one year of the birth, and pay all past due premium plus interest at the rate of 5 1/2% per year.

5. **Following adoption or placement for adoption of a Dependent.**

   If Family Coverage is not already in force, Your Dependent's Effective Date will be the date of the adoption or placement for adoption, if You send Us the completed change form within thirty-one (31) days of the event.

   If Family Coverage is already in force, Your Dependent's Effective Date will be the date of the adoption or placement for adoption. If, however, additional premium is required for the adopted Dependent, Your Dependent's Effective Date will be the date of the adoption or placement for adoption, only if You notify Us of the adoption and pay the additional premium within sixty (60) days of the adoption.

6. **Following the issuance of a court order requiring Family Coverage.**

   Your Dependent's Effective Date will be the first of the month following the presentation of a valid court order requiring Family Coverage and the completed application to Us.

7. **During Open Enrollment.**

   Your Dependent's Effective Date will be the first day following the date agreed upon by Us and the Group, provided We receive the completed application before the end of the Open Enrollment period.

Verifying Effective Date (Subscriber & Dependents)

You will not be covered by the Plan until Your Effective Date. We will notify You of Your Effective Date at the time We send You Your insurance identification (ID) card(s). Unless the Plan states otherwise, You must be Actively at Work on the day Your coverage is to become effective.

If You apply for Family Coverage with Your own application, the Effective Date for Your Dependents will be the same as Your Effective Date. If You apply for coverage for Your Dependents at a different time, their Effective Dates will differ.

How You Could Lose Eligibility

A variety of events could lead to a loss of Your Eligibility. The most common reason is leaving Your job. You can also lose Eligibility if You experience a reduction in work hours and no longer meet the twenty-one (21) hour requirement.

We have included a separate chapter, "Termination of Coverage," to provide details on the situations that would cause Your coverage to terminate.

If You lose Eligibility, Your coverage will end the last day of the month in which You no longer meet the Eligibility requirements.

How Your Dependents Could Lose Eligibility

Dependents can also lose Eligibility for a variety of reasons. Some of the more common events include the following:

1. You, the Subscriber, no longer meet the Eligibility requirements.

   Along with You, Your Dependents will lose coverage on the last day of the month in which You no longer meet the Eligibility requirements.

2. You and Your spouse divorce.

   Your spouse's coverage will end the last day of the month in which the divorce occurs. You should notify the Group within sixty (60) days of a divorce.

3. Your Dependent child gets married.

   Your Dependent child's coverage will end the last day of the month he or she marries.

   A child who marries cannot regain Dependent Eligibility at a later date.

4. Your Dependent child reaches the age of 19.

   Your Dependent child's coverage will end on the last day of the Calendar Year he or she reaches age nineteen (19) unless he or she is claimed as a Federal tax deduction by his/her parents or a full-time student at that time. The school must be an accredited academic, professional or trade school. We accept the school's definition of full-time.

   Even if Your child is a student, he or she will not be covered past the earlier of:

   a. The end of the month in which he or she ceases to be claimed as a tax deduction or a student; or

   b. The last day of the Calendar Year he or she reaches age twenty-five (25).

   However, reaching the limiting age will not end the coverage of a Dependent child who is both:

   a. Incapable of self-sustaining employment due to mental retardation or physical handicap; and

b. Chiefly dependent on You and/or Your spouse for support and maintenance. The incapacity and dependency must begin while the child is insured under this Plan. You must provide Us proof of the incapacity and dependency within thirty-one (31) days of the child's reaching the limiting age. Then You must provide proof as often as We require. This will not be more often than once a year after the two (2) year period following the child reaching the limiting age. You must provide the proof at no cost to Us.

5. Your grandchild's parent (i.e., Your Dependent child) turns eighteen (18).

   Coverage for Your grandchild will end the date Your Dependent child reaches age eighteen (18).

What to Do if You or Your Dependents Lose Eligibility

If You and/or Your Dependents lose coverage under this Plan, each of You may be entitled to COBRA, USERRA and/or state continuation benefits. Please see the chapter, "Termination of Coverage" for more details.

Medicare

If You are eligible for coverage under Medicare, contact Our office immediately so We can coordinate benefit payments with Medicare. To determine if You are eligible, call Your local Social Security Administration office when You are: a) three months from Your 65th birthday, or b) determined to be disabled by Your treating Physician.

Failure to enroll in Medicare may reduce Your benefits. Once We become aware of Your eligibility, We will pay claims as if You had enrolled in Medicare, even if You did not.

If You qualify and do not enroll in Medicare Parts A and B, it could result in significant costs to You.

Service Area Requirements

You must reside within Your Plan's Service Area to maintain Eligibility under this Plan.

Any Dependent children who reside outside the Service Area (such as college students) are required to obtain Hospital and medical services from a Network Provider, with the exception of emergency services, urgent care or outpatient behavioral health and substance abuse services as described in the "What's Covered" chapter.

Individual Reinstatements

If Your coverage ends due to one of the following, Your coverage may be reinstated when You return to work:

1. You are laid off.
2. Your employment terminates.
3. You take a non-FMLA leave of absence.
4. You elect to waive coverage during an FMLA leave period.
5. You elect to discontinue coverage during a period of military leave.

If You return to Active Work within ninety (90) days of Your lay-off date, termination date, or start date of a non-FMLA leave period, coverage is effective on the date of return. Any Probationary Periods apply only to the extent that they applied before termination. The benefits We reinstate are the benefits that You and Your Dependents would have received if coverage had been continuous.

If You return to Active Work more than ninety (90) days after Your lay-off date, termination date, or start date of Your non-FMLA leave period, We consider You to be a new Eligible person. The application period and Effective Date provisions stated earlier in this chapter, along with any Probationary Period requirements, will apply.

If You return to Active Work upon the completion of an FMLA leave period and You elect to have coverage reinstated or the Group requires Your coverage be reinstated, coverage is reinstated on the date You return from FMLA leave. The benefits We reinstate are the benefits that You and Your Dependents would have received if coverage had been continuous.

Following a military leave, if You return or request re-employment within the statutory period, coverage is reinstated on the date You return. Please see the section "Reinstatement of Coverage Following Military Leave" in the "Termination of Coverage" chapter for further details.

If You had converted Your coverage, Your conversion policy ends on the day We reinstate this coverage.

Court-Ordered Coverage

If a court orders a Member to provide coverage for health care expenses for a child of the Member and the Member is Eligible for Family Coverage under this Plan, We:

1. Provide Family Coverage under the Plan for the Member's child, if Eligible for coverage, without regard to any application period restrictions that may apply under the Plan;
2. Provide Family Coverage under the Plan for the Member's child, if Eligible for coverage, upon application by the Member, the child's other parent, the Department of Health and Family Services or the county designee under Wis. Stat. § 59.53 (5); and
3. After the child is covered under the Plan, and as long as the Member is Eligible for Family Coverage under the Plan, continue to provide coverage for the child unless We receive satisfactory written evidence that the court order is no longer in effect or that the child has coverage under another group policy or individual policy that provides comparable health coverage.

If We provide coverage under the Plan for a child of a Member who is not the custodial parent of the child, We shall do all of the following:

1. Provide to the custodial parent of the child information related to the child's Enrollment;
2. Permit the custodial parent of the child, a health care Provider that provides services to the child, or the Department of Health and Family Services to submit claims for benefits without the approval of the parent who is the Member; and

3. Pay claims directly to the health care Provider, the custodial parent of the child, or the Department of Health and Family Services as appropriate.

Note: Please see item 6 under “Application Periods for Dependents” for further information concerning the Effective Date for court-ordered coverage.

Please Read This Handbook Carefully Before Receiving Medical Care.

Termination of Coverage

In the previous chapter, We discussed Eligibility requirements and how loss of Eligibility would result in a loss of coverage under this Plan. In this chapter, You will find additional details about the specific situations that would lead to termination of Your coverage -- such as leaving Your job, Your employer's cancellation of the Group Plan and non-payment of premium. You will also find information about the timing of coverage termination.

What are Your options if Your insurance is terminated? On these pages, We have provided valuable information about Your possible rights for continuation of coverage.

When Your Coverage Ends

Your coverage will end on the earliest of the following dates:

1. The date the Contract between the Group and Us terminates. It is the Group's responsibility to notify You of the termination of coverage.
2. The last day of the month in which:
   a. Your employment terminates; or
   b. You fail to return to work from a leave of absence protected by the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA); or
   c. You have not been Actively at Work for at least thirty (30) consecutive calendar days for a period of absence not protected by the FMLA or USERRA; or
   d. You or Your Dependents no longer meet the Eligibility requirements for any reason other than a., b., or c. above.
3. The last day of the month in which the last premium contribution is made, either by You or on Your behalf.
4. The last day of the month in which You or Your Dependents are disenrolled (i.e., removed from the Plan).

   We can disenroll You and/or Your Dependents in the following circumstances:

   a. You and/or the Group fail(s) to pay the premium due on a timely basis.
   b. We discover that You or any of Your Dependents have furnished fraudulent information.
   c. You or any of Your Dependents misuse his/her identification card.
   d. You or any of Your Dependents commit acts of physical or verbal abuse which pose a threat to Providers and/or to CompcareBlue.
   e. A CompcareBlue Provider cannot maintain a satisfactory relationship with You or Your Dependents. We will not disenroll You or Your Dependents until We have tried to assist in such relationship, or given You or Your Dependents the chance to select a different Primary Care Physician. You will be told of Your rights to file a Grievance in such case.
   f. You or Your Dependents (other than Dependent children) do not live in, or move away from, Our Service Area.

We will give You at least ten (10) days written notice before disenrollment. If We disenroll You and/or Your Dependents for any reason other than for non-payment of the premium, We will make arrangements to allow You to remain on this Plan. This will continue until You find Your own coverage, until the Group's Contract renews, or until You have a chance to change insurers, whichever comes first.

No benefits are available to You after the date Your coverage ends, except as indicated below.

Benefits After Termination Of Coverage

Any benefits available under this provision are subject to all the other terms and conditions of this Plan.

1. If Your coverage ends during an Inpatient Confinement, and You are not Eligible for similar coverage under another health plan, benefits continue to be available for that Confinement until thirty (30) days after the date of termination. Benefits are not available after: a) the date the Confinement ends, or b) the payment of any Lifetime of Benefit Maximum, whichever occurs first.
2. If You are Totally Disabled on the Contract Termination Date, and You are not Eligible for regular coverage under another health plan, benefits will continue for treatment of the disabling condition(s). This continuation is subject to all Plan limitations, Exclusions and conditions. Benefits will continue until the earliest of:
   a. The date You cease to be Totally Disabled;
   b. The end of a period of twelve (12) months in a row that follows the Contract Termination Date;
   c. The date You become eligible for regular coverage under another health plan; or
   d. The payment of any Lifetime or Benefit Maximum.

   Benefits provided to You under this continuation of benefits provision shall be limited to coverage for treatment of the condition or conditions causing Total Disability and shall in no event include coverage for any dental condition.

Continuation And/or Conversion Privilege

Three laws allow You to continue Your coverage under this Plan beyond the date it would normally end.

- One is a state law, Wisconsin Statute 632.897.
- Another is a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).
- The third is also a federal law, the Uniformed Service Employment and Reemployment Rights Act (USERRA).

Check with Your Group to find out how the laws apply to You.

You may also convert Your coverage, as described below.

Continuation Of Coverage Under Wisconsin Law

Under Wisconsin Statute 632.897, an eighteen (18) month extension is available to: 1) You, the Subscriber, if You lose coverage for a reason other than misconduct on Your job, and 2) Your Dependents if You die or are divorced.

The person electing the extended coverage must have been covered under the this Plan for at least three (3) months. He or she must be a Wisconsin resident, pay timely premiums, and not be eligible for similar coverage under another group policy. The election and initial premium payment must be made within thirty (30) days of leaving the Group.

Continuation Of Coverage Under COBRA

COBRA coverage is available to You and/or Your Dependents under the following circumstances:

1. If You, the Subscriber, terminate or are terminated from Your employment (for reasons other than gross misconduct) or if Your hours are reduced, You can continue Your coverage up to eighteen (18) months.
2. If the Social Security Administration determines that You or any of Your Dependents were disabled when You lost Your job or were disable within sixty (60) days after the job loss, You and Your Dependents may be Eligible for twenty-nine (29) months of continuation.
3. If You have Family Coverage and Your Dependents lose coverage because 1) You die or are divorced, or 2) You become eligible for Medicare, Your Dependents may continue coverage up to thirty-six (36) months.
4. A child who is no longer an Eligible Dependent may also continue coverage up to thirty-six (36) months.
5. Covered retirees and widows or widowers of retirees may have longer continuation rights if the Group files a Chapter 11 bankruptcy petition.
6. You must tell the Group if You divorce or legally separate, or if Your child is ineligible within sixty (60) days of the date it happens. The person losing coverage will then be notified of the right to buy continued coverage. He or she will then have sixty (60) days to elect the coverage and pay the required premium, and another forty-five (45) days to pay the premium covering the time period before the election.

   If the terminated member is a minor, his or her parent or guardian may act on his or her behalf.
7. A terminated Subscriber may continue coverage for his or her spouse or Dependents who were also covered by this Plan. A terminated Subscriber may change coverage status from single to Family Coverage upon birth or adoption of a new child during the period of continued coverage and pay any additional premium.

8. Special COBRA rights apply to Subscribers who have been terminated or experienced a reduction of hours and who qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. These Subscribers are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the six (6) months immediately after their group health plan coverage ended.

   If You, the Subscriber, qualify for assistance under the Trade Act of 1974, You should contact the Group for additional information. You must contact the Group promptly after qualifying for assistance under the Trade Act of 1974 or You will lose these special COBRA rights.

Premium will be no more than 102% of the Group rate (if Your coverage continues beyond eighteen (18) months because of a disability. In that case, premium in the 19th through 29th months may be 150% of the Group rate).

Continued coverage ends earlier if the plan ends or if the person covered:

- Fails to pay premium timely;
- After the date of election, first becomes covered under another group health plan which contains no pre-existing condition limitations or exclusions;
- After the date of election, first becomes covered under another group health plan which contains a pre-existing condition limitation or exclusion which You have satisfied pursuant to the federal Health Insurance Portability and Accountability Act of 1996, as first enacted or later amended; or
- After the date of election, first becomes entitled to Medicare benefits.

Conversion Privilege

You may enroll in Blue Cross & Blue Shield United of Wisconsin's Conversion Medical Plan (CMP 250) instead of extending coverage, or after You exhaust Your extended benefits. The CMP 250 Plan is not available to You, however, if You are eligible for Medicare. CMP 250 provides fewer benefits than this plan.

See Your Group's Personnel Office for details. You must apply for conversion coverage within thirty (30) days of losing Eligibility. If You elected COBRA, You must elect conversion within the last one hundred eighty (180) days of Your continuation.

Continuation of Coverage During a Military Leave

Another federal law, the Uniformed Service Employment and Reemployment Rights Act (USERRA), requires that employers provide employees who are members of the military with military leave during the course of their employment. Employers must provide a cumulative total of five (5) years, and in certain instances more than five (5) years, of military leave.

During a military leave that is covered by the Act, the law requires Your Group to continue to provide coverage under this Plan for You and Your Dependents. The coverage provided must be identical to the coverage provided to similarly situated, active employees and Dependents. This means that if the coverage for similarly situated, active employees and Dependents is modified, coverage for You (the individual on military leave) will be modified.

The cost of such coverage will be:

1. For military leaves of thirty (30) days or less, the same as the employee contribution required for Actively at Work employees;
2. For military leaves of thirty-one (31) days or more, up to 102% of the full cost of the coverage, i.e., the employee and employer share.

The amount of time You continue coverage due to USERRA will reduce the amount of time You will be eligible to continue coverage under COBRA.

- **Maximum Period of Coverage During Military Leave**

Continued coverage under USERRA will terminate on the earlier of the following events:

1. The date You fail to return to Active Work with the Group following completion of Your military leave. Employees must return to Active Work within:
   a. The first full business day after completing military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service.
   b. Fourteen (14) days after completing military service for leaves of thirty-one (31) to one hundred eighty (180) days,
   c. Ninety (90) days after completing military service, for leaves of more than one hundred eighty (180) days; or
2. Eighteen (18) months from the date Your leave began.

- **Reinstatement of Coverage Following Military Leave**

The law also requires, regardless of whether continuation coverage was elected, that Your coverage and Your Dependents' coverage be reinstated immediately upon Your honorable discharge from the military service and return to employment, if You return within:

1. The first full business day of completing Your military service, for leaves of thirty (30) days or less. A reasonable amount of travel time will be allowed for returning from such military service;
2. Fourteen (14) days of completing Your military service, for leaves of thirty-one (31) to one hundred eighty (180) days; or
3. Ninety (90) days of completing Your military service, for leaves of more than one hundred eighty (180) days.

If, due to an Illness or Injury caused or aggravated by Your military service, You cannot return to Active Work within the times stated above, You may take up to:

1. Two (2) years; or
2. As soon as reasonably possible if, for reasons beyond Your control You cannot return within two (2) years because You are recovering from such Illness or Injury.

If Your coverage under the Plan is reinstated, all terms and conditions of the Plan will apply to the extent that they would have applied if You had not taken military leave and Your coverage had been continuous under the Plan. Any Probationary Periods will apply only to the extent that they applied before and the Pre-existing Condition Limitation Period will be credited as if You had been continually covered under the Plan from Your original Effective Date.

Please note that, regardless of the continuation and/or reinstatement provisions listed above, this Plan will not provide coverage for any Illness or Injury caused or aggravated by Your military service, as indicated in the chapter "What's Not Covered?"

Please Read This Handbook Carefully Before Receiving Medical Care.

What's Covered?

Your Covered Services are subject to all the terms and conditions listed in this handbook, including, but not limited to, Benefit Maximums, Deductibles, Copayments, Coinsurance, Exclusions and Medical Necessity determinations. Please refer to the "Schedule of Benefits" (located in the inside cover of this handbook) for details on the amounts You may be required to pay for Covered Services. Also be sure to refer to the chapter "Understanding Your Plan" for information on how Your Plan works and when You are required to use certain Providers.

Your benefits are described in detail below. Benefits are organized alphabetically for Your convenience. If, for some reason, You are unable to find the benefit You are looking for, please see the Index or the chapter "What's Not Covered?"

Although we describe Your benefits in a series of sections (e.g., "Allergy Testing and Treatment," "Ambulance Services," etc.), You will often find that Your claims are affected by several different sections. For instance, if You undergo a surgical procedure, Your Hospital stay will be covered under "Hospital Services," but Your Physician's Charges will be covered under "Physician's Services." As a result, You should review all the benefit descriptions that might apply to Your claims.

Alcohol and Drug Abuse Treatment

Covered Services:

Benefits are available for alcohol and drug abuse-related illnesses. Please refer to "Behavioral Health and Substance Abuse Services" in this chapter for more details.

Allergy Testing and Treatment

Covered Services:

Covered Services include allergy skin testing, antigens and injections, as Medically Necessary.

For allergy tests to be covered, the tests must be appropriately focused on specific symptoms that indicate a probability that an allergy exists.

IgE RAST tests are covered when intradermal tests are contraindicated (i.e., not appropriate).

Allergy immunotherapy injections are covered for symptomatic inhalant allergies, associated asthma, and for stinging insect venom allergies, when Your condition does not respond to other alternatives.

Services Not Covered:

- Allergy tests for non-specific or non-allergy related symptoms such as fatigue and weight gain.
- Food allergy test panels (including SAGE food allergy panels).
- Services for, and related to, many forms of immunotherapy. This includes, but is not limited to, oral immunotherapy, low dose sublingual immunotherapy, and immunotherapy for food allergies.

Ambulance Service

Covered Services:

Ground, sea and air transportation by a licensed ambulance service is covered when Your condition does not permit the use of other methods of transportation. Service must be used locally to or from a Hospital, Skilled Nursing Facility, Your home, or from the scene of an accident or medical emergency. The ambulance service must meet state staffing requirements in order to be eligible for coverage.

Services Not Covered:

- Services for, or related to, transportation not necessary for basic or advanced life support.
- Services for transportation when the patient could have been transported safely by another means.
- Services for convenience purposes.
- Cabs, including cabs for the handicapped, limousines and vans.

Anesthesia

Covered Services:

Anesthesia in connection with a covered surgical treatment or procedure is covered as is anesthesia provided in connection with covered dental care.

Covered Services include anesthesia services and supplies.

An anesthesiologist or a certified registered nurse anesthetist must render the anesthesia. The attending Physician must order the anesthesia for a covered Surgery or procedure.

Services Not Covered:

- Services of a certified registered nurse anesthetist for nerve blocks used for analgesia (i.e., relief of pain without loss of consciousness).
- Anesthesia rendered by the attending surgeon.

Behavioral Health and Substance Abuse Services

Covered Services:

Benefits are available for Covered Services rendered by a Hospital, Physician, clinical psychologist, a psychologist certified by the American Board of Professional Psychology, or any other Provider to the extent described in this section. A clinical psychologist must have been credentialed by Us or another Blue Plan in order to receive direct reimbursement; otherwise, the clinical psychologist must be under the direct supervision of a Doctor of Medicine (M.D.) and services must be billed by an M.D.

- **Inpatient Services**

Benefits are available for behavioral health or substance abuse treatment provided to a bed patient in a Hospital or any Facility for which state law mandates that benefits be paid. This includes psychotherapy, psychological testing, convulsive therapy, detoxification, and rehabilitation care.

Covered Services include night psychiatric care services which are part of a planned therapeutic treatment program.

- **Outpatient Services**

Covered Services also include non-residential services provided to You as well as Your spouse, children, parents, grandparents, brothers and sisters and their spouses, if the services are provided to enhance Your treatment. Covered Services include partial hospitalization services, prescribed drugs, convulsive therapy, psychotherapy, and psychological testing. Services must be provided by any of the following:

1. A program in an outpatient treatment Facility. The program and the Facility must be approved, established and maintained according to the state law mandating benefits.
2. A licensed Physician who has completed a residency in psychiatry, in an outpatient treatment Facility or the Physician's office.
3. A licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or a psychologist certified by the American Board of Professional Psychology.

- **Transitional Services**

Benefits are also available for transitional services. Transitional services are services more intensive than outpatient visits but less intensive than an overnight stay in the Hospital. Most often, transitional care will be rendered in a day treatment program that provides successive hours of therapy.

We cover transitional services in the following settings:

1. A certified Adult Mental Health Day Treatment Program as defined in HFS 61.75 Wis. Adm. Code.
2. A certified Child/Adolescent Mental Health Day Treatment Program as defined in HFS 40.04 Wis. Adm. Code.
3. A Certified AODA Day Treatment Program as defined in HFS 75.12(1) and (2) Wis. Adm. Code.
4. A certified Community Support Program as defined in HFS 63.03 Wis. Adm. Code.
5. A certified Residential AODA Treatment Program as defined in HFS 75.14(1) and (2) Wis. Adm. Code.
6. Intensive outpatient programs for the treatment of substance abuse disorders provided in accordance with the criteria established by the American Society of Addiction Medicine.
7. Services provided by a program certified under HFS 34.03 and provided in accordance with subchapter III HFS 34 for the period of time the person is experiencing a mental health crisis until the person is stabilized or referred to other Providers for stabilization.

- **Dependent Student Benefit**

A Dependent Student attending a School located in Wisconsin is entitled to the outpatient services described above even though services are provided without a Referral, subject to the limitations described below. This section does not increase the amount of outpatient service benefits available. As used in this section:

1. "Dependent Student" means a child Dependent Member who is enrolled in a School located in Wisconsin.
2. "School" means a vocational, technical or adult education school; a center or institution within the University of Wisconsin system; and any institution of higher education that grants a bachelor's or higher degree.

Benefits are available for a clinical assessment of the Dependent Student's behavioral health or substance abuse problems, if the assessment is conducted by:

1. A licensed Physician who has completed a residency in psychiatry, in an outpatient treatment Facility or the Physician's office; or
2. A licensed psychologist who is listed in the National Register of Health Service Providers in Psychology or a psychologist certified by the American Board of Professional Psychology.

The Provider must be located in Wisconsin and in reasonably close proximity to the School in which the Dependent Student is enrolled. We may designate the Provider.

If outpatient services are recommended in the clinical assessment described above, We pay benefits for a maximum of five (5) visits to an outpatient treatment Facility or other Provider that is located in Wisconsin and in reasonably close proximity to the School in which the Dependent Student is enrolled.

Upon the completion of the five (5) visits for outpatient services, Our Medical Director and the clinician treating the Dependent Student will review the Dependent Student's condition. They will determine whether it is appropriate to continue the Dependent Student's behavioral health or substance abuse treatment with a Provider who is in reasonably close proximity to the School in which the Dependent Student is enrolled.

The review will not be done if the Dependent Student is no longer enrolled in School or if the maximum benefit for outpatient services shown in the "Schedule of Benefits" is exhausted.

We will not pay benefits beyond the clinical assessment if the nature of the treatment recommended in the assessment will prohibit the Dependent Student from attending the School on a regular basis.

We will not pay benefits under this section after the Dependent Student has terminated his or her enrollment in the School.

- **Court-Ordered Services**

Benefits are available for Medically Necessary Hospital services, Medical Services, and outpatient services for behavioral health or substance abuse treatment rendered to a Member pursuant to an emergency detention, an involuntary commitment, or a court order to the extent benefits would have been available under this Plan.

Should such services not be rendered by a Designated Provider or a Referral Provider, We will cover benefits to the extent that benefits would have been available when:

1. Services could not have been provided through a Provider selected by Us; and
2. The Provider or Member, or other person on behalf of the Member, notifies Us within seventy-two (72) hours of the initial provision of such services.

Upon receipt of such notification, We will arrange for further Medically Necessary services to be furnished by a Designated Provider.

Reimbursement for services rendered by a Provider other than a Designated Provider will be no more than the maximum reimbursement for the services under the state medical assistance program.

Services Not Covered:

- Charges from residential treatment Facilities, unless We are specifically required to cover them by law. Residential treatment Facilities include, but are not limited to, those Facilities licensed and/or accredited as residential treatment Facilities or behavioral health Facilities. Other Facilities that are not covered include, but are not limited to, group homes for the treatment of eating disorders.
- Treatment from a social worker, even if the social worker possesses the M.S.W. or C.I.C.S.W. credential.
- Home psychotherapy.
- Non-medical ancillary services including, but not limited to, vocational rehabilitation and employment counseling, for the abuse of or addiction to alcohol and drugs, and prolonged rehabilitation services in a specialized Inpatient or residential Facility for such abuse or addiction.
- Treatment for alcoholism, drug addiction, or behavioral health issues except as described above.
- Phototherapy for seasonal affective disorder (SAD).

Note(s):

The federal Individuals with Disabilities Education Act ("Act") 20 U.S.C. § 1401 et. seq., as amended, and similar state and local laws and regulations that implement the Act, require public school districts or state or local educational agencies to provide certain services, supplies, or equipment to children, generally between the ages of three (3) and twenty-one (21), who have been diagnosed with a disability (e.g., learning, cognitive, or emotional disability). Services, supplies, or equipment of the type that are required to be provided by the school district or education agency under the Act are excluded from coverage under this Plan. This Exclusion applies to, but is not limited to, assessments for Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD). Please note that this Exclusion applies even when the services, supplies, or equipment are not actually provided by the public school district or educational agency and when the child is not enrolled in the public school system if the services, supplies, or equipment would be provided by the public school system, had the child been enrolled.

Blood

Covered Services:

Benefits are available for blood and blood plasma except when replaceable by a Blood Donor Club. Administration of blood and blood processing fees charged to the Hospital by a blood bank or blood center are also covered.

Cardiac Rehabilitation - Outpatient

Covered Services:

Coverage is available for cardiac rehabilitation on an outpatient basis. Please see "Therapy Services" in this chapter for details.

Childhood Immunizations

Covered Services:

Benefits are available to Your Dependents for appropriate and necessary immunizations, given from birth through age eighteen (18). Covered vaccines include at least all of the following:

1. Diphtheria.
2. Pertussis.
3. Tetanus.
4. Polio.
5. Measles.
6. Mumps.
7. Rubella.
8. Hemophilus influenza B.
9. Hepatitis B.
10. Varicella (chicken pox).

Chiropractor Services

Covered Services:

Benefits are available for chiropractic treatments provided by a Doctor of Chiropractic medicine when rendered within the scope of the chiropractic license. Covered Services include diagnostic testing, manipulations and treatment.

Services Not Covered:

- Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
- Nutritional or dietary supplements, including vitamins.
- Cervical pillows.
- Spinal decompression devices. This includes, but is not limited to, Vertebral Axial Decompression (Vax-D) and DRX9000.

Dental Services

Covered Services:

Benefits are available for dental services rendered by a dentist for:

1. Treatment of, and replacement of, natural teeth if the dental services are required as the result of accidental Injury. Services must be received within ninety (90) days of the accident.
2. Extraction of seven (7) or more natural teeth at one time.

3. Hospital or Ambulatory Surgical Facility Charges and anesthetics provided for dental care are covered for a Member if the Member meets any of the following conditions:
   a. The Member is under the age of five (5);
   b. The Member has a chronic disability that is attributable to a mental and/or physical impairment which results in substantial functional limitation in an area of the Member's major life activity, and the disability is likely to continue indefinitely; or
   c. The Member has a medical condition that requires hospitalization or general anesthesia for dental care.

Services Not Covered:

- Preventive care.
- Benefits for dental services provided to You under a group dental insurance policy.
- Dentistry, dental or oral surgery processes, or treatment for temporomandibular disorder, except as specified in this handbook. This also excludes orthodontics, periodontics, Orthognathic Surgery or Osteotomies.
- Oral Surgery, except as described in this handbook.
- Analgesia (i.e., laughing gas).
- Repair of damage and/or replacement of teeth due to normal activities of daily living or due to extraordinary use of the teeth.

Note(s):

Benefits are also available for certain oral surgeries and for the treatment of temporomandibular joint disease. Please see the sections "Oral Surgery" and "Temporomandibular Joint Disease" in this chapter for more details.

Diabetic Equipment, Education, and Supplies

Covered Services:

Benefits are provided for medical supplies, services, and equipment used in the treatment of diabetes, including diabetes self-management education programs.

Covered equipment includes glucometers, insulin infusion pumps, dedicated insulin infusion pump supplies, and other related supplies.

Medical supplies include insulin and other Prescription Drugs used to treat diabetes, test strips, lancets, insulin syringes, and test solutions.

Note(s):

Benefits for medical supplies are provided according to the coverage for Prescription Drugs. Please refer to that section for additional details.

Diagnostic Services

Covered Services:

Diagnostic services by a Hospital, Physician, Facility, or Other Practitioner are covered. This includes tests or procedures directed toward determining a definite condition or disease. A diagnostic service must be ordered by a Physician or Other Practitioner. Diagnostic services include:

1. X-ray and other radiology services;
2. Laboratory and pathology services; and
3. Cardiographic, encephalographic, and radioisotope tests.

Services Not Covered:

- Dental x-rays, unless this handbook states otherwise.
- Current perception threshold testing.
- Electrogastrography (EGG).
- Full body scans for screening purposes.
- Hair analysis performed by a laboratory for chemical, mineral or metallic content with the exception of testing for prenatal cocaine exposure, arsenic or mercury.
- Heart scans for screening purposes.
- Salivary hormone testing. This Exclusion does not apply to cortisol testing conducted to determine hypercortisolism.
- Video capsule endoscopy for colorectal cancer screening.

Durable Medical Equipment

Covered Services:

We cover durable medical equipment, which is equipment that:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose; and
3. Generally is not useful to a person who is not ill or injured.

The equipment must be appropriate for use in the home and meet the following criteria:

1. It must provide a therapeutic benefit to the patient in need because of a medical condition and/or Illness.
2. It must be prescribed by a Physician or Other Practitioner practicing within the scope of his or her license. Claims for equipment must be accompanied by Your Physician or Other Practitioner's written certification of Medical Necessity. However, this certification does not in itself entitle You to benefits.
3. It should not have significant non-medical uses or be used primarily for comfort or convenience (e.g., environmental control equipment such as vaporizers, humidifiers, and air conditioners.)

Durable medical equipment also includes oxygen and rental of equipment related to its administration.

Repair of equipment is also covered, unless repairs are required as a result of Your negligence or abuse.

- **Rental Versus Purchase of Equipment**

We cover the purchase or rental, at Our option, of durable medical equipment. However, We do not cover rental fees that are more than the total cost of purchasing the piece of equipment. For Our purposes, "purchase" is the equivalent of twelve (12) monthly rental payments. The twelve (12) monthly payments include rental of the same or similar piece of equipment, regardless of the Provider from whom the equipment is rented. However, if a Member has not rented the piece of equipment for twelve (12) months and there is a gap in the rental of more than sixty (60) days, the rental months prior to the sixty (60) day gap will not be counted toward the twelve (12) monthly payments limit that We consider to be a "purchase." This limitation on rental prices does not apply to the supply of oxygen and oxygen equipment.

- **Return of Equipment**

When Your coverage terminates, You must return all rented equipment to the Provider, or contact the Provider to make arrangements for continued rental. (The continued rental will not be covered under this Plan.) You must also return all purchased equipment to the Provider when You purchase replacement equipment. Only equipment that the Provider has irreversibly customized is Your property.

Services Not Covered:

- Bladder stimulators (pacemakers).
- Items and self-help devices not chiefly medical in nature.
- Items for comfort and convenience.
- Physician's equipment.
- Disposable supplies unless provided in connection with direct Physician care or covered home care.
- Exercise and hygienic equipment.
- Deluxe equipment (except when deluxe features are necessary for the effective treatment of Your condition, or required in order for You to operate the equipment Yourself).

Emergency Care

Covered Services:

Benefits are available for services or supplies that You require in the emergency room to treat an emergency medical condition.

An emergency medical condition is a medical condition that involves acute symptoms of sufficient severity, including severe pain, that would lead a prudent layperson with an average knowledge of health and medicine to reasonably conclude that a lack of immediate medical attention will likely result in:

1. Serious jeopardy to Your health, or, for a pregnant women, serious jeopardy to the health of the woman or her unborn child;
2. Serious impairment to Your bodily functions; or
3. Serious impairment of one or more of Your body organs or parts.

It includes traumatic bodily Injuries that result from an accident.

Services Not Covered:

- Elective, routine, or follow-up care.

Eye Examinations

Covered Services:

Medically Necessary vision examinations are covered. This includes services to treat disease or injury to the eyes. Benefits are also available for routine examinations for eyeglasses.

Benefits include examinations for the prescription or fitting of eyeglasses or contact lenses, and for the first pair of eyeglasses or contact lenses for the following conditions:

1. For aphakia;
2. For keratoconus;
3. Following cataract surgery.

Lenses implanted during cataract Surgery are also covered.

Services Not Covered:

- Examinations for the fitting of eyeglasses or contact lenses, except as indicated above.
- Radial keratotomy, LASIK, photorefractive keratectomy, and any other Surgery to correct refractive disorders such as myopia, hyperopia, or stigmatic error, with the exception of Surgery to correct cataracts and keratoconus.
- Eyeglasses, frames, contact lenses, and other vision hardware, unless the Vision Supplies rider is included with this Plan.

Foot Care

Covered Services:

Routine foot care, including the cutting or removal of corns and calluses, trimming, cutting, clipping, or debriding of nails is covered when:

1. You have a systemic condition, such as metabolic, neurologic, or peripheral vascular disease, or a systemic condition with severe circulatory problems that require foot care by a professional; and
2. Your condition requires that this care be received from a skilled professional.

You must currently be under the care of a Physician who can document that You have a condition requiring these services in order for the services to be covered.

Treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), and tendonitis that result from or are associated with partial displacement of the structures of the foot is covered when Medically Necessary.

Medically Necessary Surgery required to treat a foot Injury, or to improve the function of the foot, is also a Covered Service.

Services Not Covered:

- Routine foot care, except as noted above. This Exclusion includes care, such as pedicure treatments (e.g., cleaning, soaking, applying skin creams) performed in the absence of localized Illness, Injury, or symptoms involving the foot.
- Treatment of flat foot.
- Treatment of subluxations of the foot.
- Foot orthotics, except as indicated under "Orthotics."

Hearing Examinations

Covered Services:

Covered Services include Medically Necessary hearing examinations and a routine screening audiometry examination.

Services Not Covered:

- External or internal mechanical hearing aids, whether removable or surgically implanted, or examinations for the prescription or fitting of hearing aids.
- Services, supplies, or equipment provided by or obtained from an audiologist, a hearing aid dealer or hearing aid fitter.
- Cochlear implants.

Home Care

Covered Services:

Benefits are available for home care, which includes:

1. Home nursing care rendered by, or under the supervision of, a registered nurse;
2. Home health aide services which are Medically Necessary as part of the home care plan and which are rendered under the supervision of a registered nurse or medical social worker. Such services shall consist solely of caring for the patient;
3. Physical or occupational therapy, speech-language pathology, or respiratory care;
4. Medical supplies, drugs and medications prescribed by a Physician, and laboratory services by or on behalf of a Hospital, if necessary under the home care plan, and to the extent that such items would have been covered had the patient been hospitalized;
5. Nutrition counseling provided by or under the supervision of a registered dietician or a dietician certified under subch. IV of chap. 448 when Medically Necessary as part of the home care plan; and
6. Evaluation of the need, and development of a plan, for home care by a registered nurse (R.N.), a physician extender, or medical social worker when approved or requested by the attending Physician.

Home care is covered if Your Physician prescribes and actively supervises the services and if the following circumstances are present:

1. You would have to be confined in a Hospital or Skilled Nursing Facility if You did not receive home care;

2. Medically Necessary care and treatment are not available from Your immediate family or other people residing with You without causing undue hardship. Your immediate family means Your spouse, children, parents, grandparents, brothers and sisters and their spouses;

3. The services must be provided or coordinated by a state-licensed or Medicare-certified home health agency or certified rehabilitation agency. The plan must be approved in writing and reviewed at least every two (2) months. We may decide that a longer time between reviews is sufficient.

If You were hospitalized before the start of home care, Your home care plan must be approved by the Physician who was Your primary Provider of services during Your hospitalization.

Benefits are only available for part-time or intermittent nursing care. The cost for home care shall not exceed the cost of placing You in a Skilled Nursing Facility or intermediate care Facility.

Services Not Covered:

- Custodial Care and services to aid in the activities of daily living.
- Food, housing, homemaker services, home-delivered meals.
- Any services not specifically listed above as a home care service.
- Services or supplies not included in the home care plan established for You.
- Services provided by Your immediate family or any other person residing with You.
- Services for, or related to, respite care.

Home Infusion Therapy

Covered Services:

Benefits are available for equipment, services, and supplies provided during the course of home infusion therapy.

Services Not Covered:

- Services for, or related to, nursing services to administer therapy that you or another caregiver can be successfully trained to administer.
- Services that do not involve direct patient contact, such as delivery charges and recordkeeping.

Hospice Care

Covered Services:

Benefits are available for hospice care arranged and approved by Your Physician if You are terminally ill. Terminally ill means that You have a medical prognosis of limited life expectancy, usually six (6) months or less.

Hospice care is an approach to caring for terminally ill individuals that stresses palliative care (relief of pain), as opposed to curative care. Covered Services must be related to the palliation or management of Your terminal Illness, symptom control, or enable You to maintain activities of daily living and basic functional skills.

Covered Services include hospice care in the home or short-term Inpatient care in a Skilled Nursing Facility, Hospital, or other Facility We have approved. Short-term Inpatient care is only available when the care is necessary to control pain and manage Your symptoms, to provide an interval of relief to the family member or caregiver that takes care of You everyday, and if the care cannot be provided in the home or an on outpatient basis.

Covered Services also include supportive care rendered by a social worker who possesses an M.S.W. or a skilled nurse when it is required by the patient's condition and approved or requested by the attending Physician. Supportive care includes the evaluation of the personal, emotional, social, and environmental circumstances related to or resulting from a patient's Illness, and guidance and assistance given during the patient's Illness for the purpose of preparing patient and family to imminent death.

A plan of care must be established before services are provided. You or Your Provider should contact Us prior to arranging for hospice care to select a hospice Provider. Your selected hospice Provider will be responsible for coordinating Your care.

Services Not Covered:

- Treatment to cure a terminal illness.
- Care received from another hospice Provider that was not arranged by Your chosen hospice.

Hospital Services

Covered Services:

Inpatient and outpatient Hospital services are covered as described below.

- **Inpatient Services**

Covered Services include room accommodations such as room and board, nursery care, and general nursing services and supplies. Room accommodations include rooms in coronary or intensive care units, when Medically Necessary.

Benefits are also available for all services, equipment, medications, and supplies that are furnished, provided by and used by You in the Hospital to which You are admitted as a registered patient.

Room accommodations are limited to a semi-private room or a ward room unless a private room is prescribed as Medically Necessary or the Hospital has no semi-private or ward rooms available. If You occupy a private room which is not prescribed as Medically Necessary and the Hospital has no semi-private or ward rooms available, the maximum amount We will pay will be the average of the Hospital's Charge for all of its semi-private or ward room accommodations.

- **Pre-Admission Testing**

Pre-admission testing performed within seven (7) days before a Hospital admission is a Covered Service. Pre-admission testing does not include tests and studies done to establish a diagnosis.

If the Inpatient admission is unexpectedly cancelled and the pre-admission testing services are properly identified, We will pay for testing as an outpatient service.

- **Outpatient Services**

Covered Services also include outpatient services. We encourage Members to utilize outpatient services whenever possible.

All claims for Hospital Services and Ambulatory Surgical Facilities will be reviewed to determine the most appropriate location for care.

Services Not Covered:

- Convenience items, such as radio, television, telephone, or parking.
- Inpatient Hospital admissions primarily for physical therapy and for x-ray or radiation therapy.
- Pre-admission testing if the tests are repeated when You are admitted to the Hospital.
- Procedures that can be safely performed on an outpatient basis or in an Ambulatory Surgical Facility will not be covered on an Inpatient basis.
- Procedures that can safely be performed in a doctor's office will not be covered on an outpatient Hospital basis or in an Ambulatory Surgical Facility.

Kidney Disease Treatment

Covered Services:

Benefits are available for kidney disease treatment including dialysis, transplantation, and donor-related services.

Note(s):

Members with End Stage Renal Disease (ESRD) should contact Medicare about enrollment and benefit options.

Laboratory Services

Covered Services:

Benefits are available for laboratory services. Please see "Diagnostic Services" in this chapter for details.

Lead Poisoning Screening

Covered Services:

Benefits are available for blood lead tests for Your Dependents under six (6) years of age, as required by the Department of Health and Family Services.

Mammography Examinations

Covered Services:

Your Plan covers Medically Necessary mammograms and annual mammograms for women age forty (40) or older.

Maternity and Reproductive Services

Covered Services:

Coverage for maternity services includes services rendered by a Hospital or Physician for normal pregnancy, Complications of Pregnancy*, and interruptions of pregnancy. This includes all maternity-related Medical Services for prenatal care, delivery, and post-natal care.

**Complications of Pregnancy is defined an Illness or Injury superimposed upon an otherwise normal pregnancy. The Illness or Injury must have the potential to affect the course or outcome of the pregnancy, or the health of the mother or fetus. Examples of Complications Of Pregnancy are preeclampsia, toxemia, gestational diabetes, hyperemesis gravidarum, ectopic pregnancy, miscarriage, and gynecological Surgery performed in the six (6) week postpartum period (other than elective sterilization) if the Surgery is in connection with or results from the pregnancy.*

Complications do not include false labor, occasional spotting, prescribed rest during the pregnancy, morning sickness, Caesarean section, breach presentation, and similar conditions associated with a difficult pregnancy.

Under federal law, We may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn to less than forty-eight (48) hours following vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours, or ninety-six (96) hours, as applicable. In any case, as provided by federal law, We may not require that a Provider obtain authorization from Us before prescribing a length of stay which is not in excess of forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours following a cesarean section.

- **Infertility Services** Covered Services also include services related to determination and diagnosis of infertility.

  Services Not Covered:

  - Services for an elective abortion. Maternity services do, however, include Covered Services provided to treat an Illness or Injury resulting from an elective abortion.
  - Any services, supplies, or equipment related to surrogate mother services.
  - Reversals of tubal ligations and vasectomies.
  - Transsexual surgery or any treatment leading to or connected with transsexual surgery.
  - Treatment of sexual dysfunction which is not related to organic disease.
  - Treatment of infertility. This includes, but is not limited to, in-vitro fertilization, artificial insemination, and all other insemination and/or fertilization services intended to induce ovulation and/or to promote spermatogenesis and/or to achieve conception. This Exclusion also applies to Charges for infertility drugs.
  - Treatment provided in preparation for or connected with a non-covered infertility service.
  - Services for, or related to, sperm banking.
  - Sperm penetration assay (SPA).

Nurse Practitioner Services

Covered Services:

Benefits are available for Papanicolaou tests (pap smears), pelvic examinations, and associated diagnostic services provided by a licensed Nurse Practitioner if benefits are available for the services when provided by a Physician. The Nurse Practitioner must be practicing within the scope of his or her license in order for benefits to be covered.

Nursing Services

Covered Services:

Covered Services include skilled nursing services if arranged and approved by Your Physician. Nursing services are considered skilled if they can only be provided by or under the direction of a registered nurse.

Services Not Covered:

- Custodial Care.
- Private duty nursing.

Office Visits

Covered Services:

Office Visits are a Covered Service. Please see "Physician's Services" in this chapter for more details.

Oral Surgery

Covered Services:

The following Surgeries are Covered Services when performed by an oral surgeon or Physician:

1. Alveolectomy - The leveling of structures supporting teeth for the purpose of fitting dentures. We do not cover alveolectomy when it is performed in connection with the extraction of natural teeth.
2. Apicoectomy - Excision of apex of tooth root.
3. Excision of exostoses of the jaws and hard palate.
4. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
5. External incision and drainage of cellulitis.
6. Frenectomy - Incision of any midline fold of tissue between the jaws and lips and between the lower jaw and tongue.
7. Gingival curettage under general anesthesia.
8. Gingivectomy - Excision of loose gum tissue to eliminate infection.
9. Incision of accessory sinuses, salivary glands or ducts.
10. Periodontal surgery - The surgical treatment of periodontal diseases of the gums and supportive tissues of the teeth.
11. Residual root removal.
12. Root amputation.
13. Surgical procedures required to correct Injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth.
14. Surgical reduction of dislocations of, and excision of, the temporomandibular joints.
15. Surgical removal of impacted teeth.
16. Treatment of fractures of facial bones.
17. Vestibuloplasty - The surgical modification of the gingival mucous membrane.

We pay benefits for the following services and supplies related to a covered oral Surgery:

- Medically Necessary local or general anesthesia and intravenous sedation, when related to a covered oral Surgery;
- One consultation that results in an oral Surgery; and
- Radiographic studies.

Services Not Covered:

- Routine dental services.
- Orthodontics, periodontics, Osteotomies, and Orthognathic Surgery.
- Oral Surgery processes or treatment for temporomandibular disorder except as specified in this handbook.
- Tooth implantation and related services.

Organ Transplants

Covered Services:

Benefits are available for the following transplants:

1. Kidney.
2. Cornea.
3. Non-experimental / investigational bone marrow, including hematopoietic stem cell support.
4. Heart.
5. Lung.
6. Heart and lung combined.
7. Liver.
8. Pancreas.

The organ must be from a human donor. The donor, even if not a Member, may also be Eligible for benefits related to the removal of the organ. Donor benefits are limited to benefits not available to the donor from any other source. Benefits related to the procurement of the transplant organ, including tissue typing, donor searches, surgical removal procedures, storage, and transportation of the procured organ are also available.

- **Preauthorization** With the exception of kidney benefits, Preauthorization is required before We will cover benefits for a transplant. Your Physician must certify, and We must agree, that the transplant is Medically Necessary. Your Physician should submit a written request for Preauthorization to Us as soon as possible to start this process. Failure to obtain Preauthorization will result in a denial of benefits.

- **Waiting Period** To be Eligible for organ transplant benefits, You must be continuously Enrolled under this Plan for a period not less than three hundred sixty-five (365) days. Time served under this Group's previous plan for a covered transplant will be credited toward the three hundred sixty-five (365) day waiting period. We will only credit time for those transplants which were a covered benefit under the Group's previous plan.

  This waiting period is not the same as a Pre-existing Condition Limitation Period nor will Creditable Coverage provisions apply. The waiting period is a separate waiting period for transplants only.

  The waiting period does not apply to kidney transplants.

Services Not Covered:

Services, supplies, or equipment (even if associated with a covered organ transplant) for:

- Procedures involving non-human and artificial organs.
- Lodging expenses.
- Transportation expenses except for Medically Necessary ambulance service.
- Any organ transplant not specifically listed as a Covered Service.
- Services and supplies required in connection with or as the result of a non-covered organ transplant procedure.
- Purchase price of an organ that is sold rather than donated to a Member.

For purposes of these Exclusions, organ transplants include bone marrow and stem cell transplants.

Orthotics

Covered Services:

Covered orthotics include appliances and apparatus to support, align, or improve the function of moveable parts of the body. Orthotics also include items that prevent or correct deformites.

Covered orthotic devices include:

1. Orthotics, orthotic devices, orthopedic braces, and orthopedic appliances.
2. Custom-made foot orthotics for patients with diabetes mellitus if Medically Necessary for foot or ankle problems. The orthotic must be worn inside the shoe on a consistent daily basis (i.e., not for a single type of activity such as tennis, golf or running). To qualify for coverage, the Member must have one (1) or more of the following conditions:
    a. History or partial or complete foot amputation.
    b. History of previous foot ulceration.
    c. History of pre-ulcerative callus.
    d. Peripheral neuropathy with evidence of callus formation.
    e. Poor circulation.
    f. Foot deformity.

Covered Services include:

1. All services and supplies necessary for the design, selection, measurement, fitting, and use of the orthotic.
2. Adjustment or repair of the orthotic when due to normal wear and tear or to a change in Your condition.
3. Replacement of the orthotic, if adjustments will not suffice, due to a change in Your condition or due to irreparable damage to the existing orthotic. Replacement will not be covered, however, if the damage is due to Your negligence or abuse.

Services Not Covered:

- Orthopedic shoes, shoe modifications, and other support devices for the feet (such as shoe inserts and orthotics) except as specifically described above for Members with diabetes mellitus.
- Deluxe features of diabetic shoes.
- Inserts used in non-covered shoes.
- Orthotics for flat feet, sandal orthotics, and over-the-counter or off-the-shelf orthotics.
- Devices used for sports, recreational activity, or competitive athletic activity.
- Routine periodic servicing, such as testing, cleaning, and checking of the device.
- Expenses due to damage that results from Your negligence or abuse.

Physician Services

Covered Services:

Physician services include services provided in the Physician's office or clinic, Your home, Hospital, or another Facility.

If Your Physician recommends a specific treatment or makes a diagnosis, You may obtain a second opinion from another Physician. The second opinion is usually for a consultation only.

Inpatient Physician care includes consultations provided by another Physician at the request of the attending Physician. It does not include staff consultations required by Hospital rules.

Covered Services include one Inpatient visit by a Physician other than the delivery Physician for an apparently healthy newborn.

Preventive Care

Covered Services also include preventive care. Preventive care is care provided in the absence of a complaint and includes examinations and related services:

1. To screen for specific disease(s) when there is no evidence of the disease(s); or
2. For primary or secondary preventive (routine) care, including immunizations, well-baby care, and monitoring.

Services Not Covered:

- Benefits for administrative examinations and their related services. This includes examinations performed for occupation or employment, purchase of insurance, and in preparation for litigation.
- Immunizations required for travel outside the United States.

Note(s):

Lead poisoning screening, mammograms and childhood immunizations are covered separately. Please refer to those sections for details.

Prescription Drugs

Covered Services:

Covered Services include Prescription legend drugs which:

1. May only be dispensed according to a written Prescription from a Physician, under federal law;
2. Are approved for human use by the Food and Drug Administration; and
3. Are dispensed by a Pharmacist, acting within the scope of his/her license, on or after Your Effective Date for Your outpatient use.

Covered Services also include any Prescription legend drug that is:

1. Approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness;
2. In or has completed a phase 3 clinical investigation; and
3. Prescribed and administered in accordance with the treatment protocol approved for the drug.

Benefits are only available for Prescription Drugs up to a thirty (30) day supply. A thirty (30) day supply is determined by the individual drug's dosing guidelines. We retain the right to establish dosing guidelines.

We regularly review all Prescriptions to determine if current use is appropriate and if We should continue to cover future Prescriptions. The fact that We cover an initial Prescription is not a guarantee that We will cover future Prescriptions. Please feel free to contact Us if You have questions about whether benefits will be available for Your Prescriptions.

- **Step Care Program**

Some Prescription Drugs are best used after other effective, usually less expensive, first-line drug therapies have been tried first. These Prescription Drugs are known as "Step Care" products. When a Prescription Order for a Step Care product is presented to the Pharmacy, Our online claims processor will search past claims to determine if a first-line therapy has been tried. If it has, the Prescription Drug will be eligible for benefits. However, if a first-line therapy has not been tried, the claim for the Prescription Drug will be denied. We will advise Your Pharmacist of the Prescription Drug alternatives available.

- **Diabetic Supplies**

Covered medical supplies for the treatment of diabetes include insulin, blood glucose testing strips, lancets, insulin syringes, and test solutions. Benefits are also available for other Prescription Drugs used to treat diabetes.

Equipment for the treatment of diabetes including glucometers, insulin infusion pumps and dedicated insulin infusion pump supplies, or related supplies is covered under the "Diabetic Equipment, Education and Supplies" section of this chapter.

- **Contraceptives**

Covered Services also include contraceptives. This includes oral contraceptives, contraceptive patches, IUDs, diaphragms, and any other Prescription Drug used for birth control.

- **Maintenance Drug Benefit**

Specific Prescription Drugs may be obtained in a ninety (90) day quantity from the CompcareBlue and/or a Network Pharmacy. The Pharmacist will advise You if the Prescription Drug is available under this benefit.

- **Preauthorization** Certain Prescription Drugs require Preauthorization. This is required, but not limited to, when:

  1. The Charge for any single Prescription item is more than $250; or
  2. The Prescription Drug is an injectable medication or growth hormone that has been specifically approved by the Pharmacy and Therapeutics Committee for self-administration.

  You or the Pharmacy must contact the CompcareBlue Pharmacy to obtain Preauthorization. The telephone number and location of the CompcareBlue Pharmacy is included in the pharmacy directory.

  Once approved, the Pharmacy will be authorized to dispense the medication. Future refills must be distributed by the CompcareBlue Pharmacy. Covered Prescription Drugs distributed by the CompcareBlue Pharmacy may be obtained in one of the following ways:

  1. You may pick up the Prescription at the CompcareBlue Pharmacy, or
  2. The medication may be mailed to You.

  Other Prescription Drugs, in addition to those mentioned above, also require Preauthorization. We will advise Your Pharmacist if this is required and let Your Pharmacist know who he/she should contact to obtain Preauthorization. If You have a question about the status of a Preauthorization request, You may contact Customer Service.

- **Payment** When Prescription Drugs are dispensed by a Network Pharmacy, We pay the benefits directly to the Pharmacy. If the Pharmacy requests that You pay the full cost of the Prescription, You should confirm that the Pharmacy is still one of Our Network Pharmacies. If it is, You should ask the Pharmacy to submit the claim directly to Us. If the Pharmacy still requires You to pay the full cost of the Prescription, We will reimburse You the negotiated price of the Prescription Drugs, less any applicable Copayment, Deductible, and/or Coinsurance.

  Services Not Covered:

  - Benefits for Prescription Drugs in excess of a thirty (30) day supply.
  - Prescription Drugs furnished upon a Prescription Order written before Your Effective Date.
  - Prescription Drugs not approved by the U.S. Food and Drug Administration (FDA).
  - Prescription Drugs that are Experimental / Investigational. This Exclusion does not apply to any prescription legend drug that is:
    a. Approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness;
    b. In or has completed a phase 3 clinical investigation; and
    c. Prescribed and administered in accordance with the treatment protocol approved for the drug.

- Prescription Drugs, appliances, or prosthetic devices, except as specified in this handbook.
- Prescription Drugs, or a Deductible applied to Prescription Drugs, if benefits are provided to You under one of Our group Prescription Drug policies.
- Prescription Drugs or other services dispensed to You for purposes other than Your own use.
- Prescription Drug refills which are:
  a. More than the number specified by the Prescriber; or
  b. Dispensed more than one (1) year from the original Prescription Order date.
- Any Prescription Drug prescribed as either in connection with, or as a result of, a non-covered organ transplant.
- Prescription drugs intended primarily to improve appearance, but not intended to restore normal bodily function or to correct deformity resulting from disease, trauma, or a previous therapeutic process that is a Covered Service.
- Injectable drugs that We have not specifically approved for self-administration.
- Any claim or demand for Injury or damage which either arises out of or is connected to the manufacturing, compounding, dispensing, or use of any Prescription Drug.
- Infertility drugs.
- Any portion of a Charge which is more than the Prescription Charge (e.g., postage, shipping, handling).
- Over-the-counter medications and Prescription Drugs that have an over-the-counter equivalent.
- Non-drug medical items which may be commonly received from a Pharmacy by Prescription Order, including but not limited to, durable medical equipment.
- Smoking cessation programs, including services or supplies required in connection with or as a result of such programs.
- Weight loss drugs including, but not limited to, food or liquid diet supplements and other Prescription Drugs.
- Nutritional or dietary supplements. This includes, but is not limited to, those supplements that by law do not require either the written Prescription of a Physician or dispensing by a licensed Pharmacist. It also includes food replacements, such as infant formula.
- Refills of lost or stolen medications.
- Compounded hormones.
- Prescription Drugs for gene therapy.

- Growth hormone in adults when used as anabolic therapy.
- Immunotherapy for food allergies.
- Laetrile and related substances.
- Oral or topical medications for toenail onychomycosis treatment except when Medically Necessary for diabetic or immunocompromised patients.

Note(s):

The Prescription Drugs listed below, when covered, will be paid as a medical benefit, not as a Prescription Drug benefit. This means that these medications will subject to the Plan's Deductible and Coinsurance, and not the Copayments listed under "Prescription Drugs" in the "Schedule of Benefits."

- Prescription Drugs intended for administration in the Physician's office or in an outpatient clinic that are not designated as self-injectable medications by the Pharmacy and Therapeutics Committee. These medications include, but are not limited to, Lupron Depot injections, Zoladex injections, and Sandostatin Depot injections.
- Prescription Drugs dispensed to You while You are a registered patient in a Hospital, nursing home, or other institution.
- Prescription Drugs for home infusion therapy.

Prosthetics

Covered Services:

Prosthetic appliances include devices and supplies which replace all or part of an internal body organ or external body member (including contiguous tissue). It also includes appliances that replace all or part of the function of a permanently impaired or malfunctioning internal body organ or external body member.

Covered appliances include:

1. Any internal artificial device implanted surgically within the body.
2. Any external device that is an item of regular Hospital working equipment and is used within the Hospital.
3. External prostheses such as pacemakers and artificial limbs (including replacement, repairs, fittings, and adjustments).
4. Ostomy supplies.

Covered Services include:

1. The initial purchase of the prosthetic and all services necessary for the design, selection, measurement, fitting, and use of the prosthetic.
2. Adjustment or repair of the prosthetic when due to normal wear and tear or due to a change in Your condition (e.g., growth or a change in Your medical condition).
3. Replacement of the prosthetic, if adjustments will not suffice, due to a change in Your condition or to irreparable damage to the existing prosthetic. Replacement will not be covered, however, if the damage is due to Your negligence or abuse.

- **Deluxe and Custom Models**

Equipment and services are limited to those items that are Medically Necessary. Reimbursement for non-standard models is limited to the cost of the standard equipment unless Your Physician certifies, and We agree, that the deluxe or custom equipment is Medically Necessary.

Services Not Covered:

- Artificial heart including permanent ventricular assist devices.
- Deluxe equipment except as indicated above.
- Dental appliances, eyeglasses, or non-rigid appliances and supplies.
- Services covered by a homeowners or similar insurance policy.
- Devices used for sports, recreational activity, or competitive athletic activity.
- Routine periodic servicing, such as testing, cleaning, and checking of the device.
- Expenses due to damage that results from Your negligence or abuse.
- Replacement prosthetics when purchased as an improved model for appearance, convenience, or comfort.

Skilled Nursing Facility

Covered Services:

Benefits include Medically Necessary Inpatient care in a semi-private or ward room of a Skilled Nursing Facility if arranged and approved by Your Physician. Benefits are available subject to the following:

1. You must require daily skilled care by licensed professionals;
2. Transfer to a Skilled Nursing Facility must take place within twenty-four (24) hours of release from a Hospital;
3. Confinement in a Skilled Nursing Facility must be for the continued treatment of the same medical or surgical condition for which You were treated at the Hospital; and
4. Your Physician must certify when You are admitted that the care is Medically Necessary. He or she must recertify this on a weekly basis.

If You occupy a private room, the allowance for room accommodations shall be limited to the Skilled Nursing Facility's Charge for all of its semi-private or ward room accommodations.

Services Not Covered:

- Custodial Care - such as help walking, getting in and out of bed, eating, dressing, bathing, and taking medicine.

Surgery

Covered Services:

Benefits are available for Surgery (other than oral surgery) in a Hospital or Ambulatory Surgical Facility by a Physician or Other Practitioner. Covered Services include pre- and post-operative services. Later surgical procedures (e.g., suture, cast removal) which are normally considered part of the Charge for the initial surgical procedure, are considered for payment as a separate service only when performed by a Physician other than the operating surgeon.

Surgery services include outpatient electroshock therapy.

When We determine assistance is Medically Necessary, Covered Services include the services of a Physician or Other Practitioner who actively assists the operating surgeon to perform a covered Surgery.

- **Reconstructive Surgery**

Surgery to restore normal bodily function, or to correct deformity resulting from disease, trauma, or a previous therapeutic process is a Covered Service.

Breast reconstruction benefits include:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Reconstructive oral surgery includes only those oral surgeries specified as Covered Services in the "Oral Surgery" section.

- **Congenital Defect Surgery**

Surgery that provides functional repair or restoration of any defective body part when repair is necessary to achieve normal body functioning is a Covered Service. The defect must have existed at birth.

Services Not Covered:

- Surgeries, procedures, treatments or Prescription Drugs, and their related Hospital and professional services intended primarily to improve appearance, but not intended to restore normal bodily function or to correct deformity resulting from disease, trauma, or a previous therapeutic process that is a Covered Service. This Exclusion includes, but is not limited to, rhinoplasty and breast reduction Surgery. This Exclusion does not apply to contralateral breast reconstruction following mastectomy.
- Lysis of epidural adhesions.

Note(s):

Be sure to review other sections of this Plan that may discuss specific types of Surgeries (e.g., vision, dental, reproductive services), which are subject to their own limitations or Exclusions.

Temporomandibular Disorder Treatment

Covered Services:

Diagnostic procedures and Medically Necessary surgical or non-surgical treatment for the correction of temporomandibular disorders are covered if the following conditions are met:

1. The condition is caused by congenital, developmental, or acquired deformity, disease or Injury;
2. The procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition under the accepted standards of the profession of the health care Provider rendering the service; and
3. The purpose of the procedure is to control or eliminate infection, pain, disease, or dysfunction.

Benefits are also available for prescribed intraoral splint therapy devices.

Services Not Covered:

- Adjustments to splints; lost or broken splints.

Therapy Services

Covered Services:

Your Plan covers the following therapy services by a Hospital, Physician, or Other Practitioner:

1. Radiation therapy.
2. Chemotherapy.
3. Dialysis treatment.
4. Physical therapy.
5. Respiration therapy.
6. Occupational therapy.
7. Speech therapy.
8. Outpatient cardiac rehabilitation. Treatment must begin within three (3) months of Hospital Confinement for acute myocardial infarction, coronary artery bypass graft, coronary angioplasty, cardiac valve replacement or repair surgery, or chronic stable angina pectoris.

Services Not Covered:

- Therapy services other than those noted above.
- Phase III cardiac rehabilitation services and structured exercise programs.
- Services from a masseuse / massage therapist.
- Maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves Your present level of functioning and prevents loss of functioning, but which does not result in any additional improvement.

Note(s):

The federal Individuals with Disabilities Education Act ("Act") 20 U.S.C. § 1401 et. seq., as amended, and similar state and local laws and regulations that implement the Act, require public school districts or state or local educational agencies to provide certain services, supplies, or equipment to children, generally between the ages of three (3) and twenty-one (21), who have been diagnosed with a disability (e.g., learning, cognitive, or emotional disability). Services, supplies, or equipment of the type that are required to be provided by the school district or education agency under the Act are excluded from coverage under this Plan. This Exclusion applies to, but is not limited to, assessments for Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD). Please note that this Exclusion applies even when the services, supplies, or equipment are not actually provided by the public school district or educational agency and when the child is not enrolled in the public school system if the services, supplies, or equipment would be provided by the public school system, had the child been enrolled.

Urgent Care	**Covered Services:** Benefits are also available for services or supplies that You require for an Injury or Illness which requires prompt medical attention, but which is not life-threatening. This would include conditions such as worsening sore throats, sprains, cuts, cuts with controlled bleeding, minor bone fractures, and infections. Urgent care can often be provided at Your Physician's office. Many Medical Groups are open evenings and weekends to handle "off hour" problems. Urgent care can also be provided at an urgent care Facility, if You have a Referral from Your PCP. **Services Not Covered:** • Elective, routine, or follow-up care. • Care required as a result of circumstances or conditions which You could reasonably have foreseen.
Vision Examinations	**Covered Services:** Please see "Eye Examinations" in this chapter for details.
X-ray Services	**Covered Services:** Please see "Diagnostic Services" in this chapter for details.

Please Read This Handbook Carefully Before Receiving Medical Care.

What's Not Covered?

To make sure You receive the maximum benefits allowed, You need to know what is covered as well as what is not. In addition to the Exclusions mentioned under each benefit section in the "What's Covered?" chapter and in Your "Schedule of Benefits," the services, supplies, and/or equipment listed in this chapter are also excluded from coverage. Please be sure to review each of these chapters carefully to obtain a full understanding of the benefits Your Plan will or will not cover.

No benefits are available for the following:

1.	**Acts of War**	Services, supplies, or equipment required for an Illness contracted or Injury sustained as a result of: a. War, whether declared or undeclared; or b. Service in the armed forces of any country or state.
2.	**Additional After Hours Charges**	Additional Charges beyond the Charges for basic and primary services for services requested after normal Provider service hours or on holidays.
3.	**Alternative Treatments**	Forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health, including but not limited to: a. Acupressure, acupuncture, and electroacupuncture. b. Aromatherapy. c. Auditory integration therapy (AIT). d. Colonic irrigation. e. Craniosacral therapy, craniopathy, and cranial osteopathy. f. Hypnotism. g. Homeopathic remedies. h. Magnetic innervation therapy, electromagnetic therapy, and electrical pelvic floor stimulation therapy as treatment for urinary incontinence. i. Massage therapy by a non-covered Provider (e.g., massage therapist). j. Neural organization therapy. k. Neurofeedback. l. Rolfing (also known as Structural Integration). m. Relaxation therapy (including yoga, visual imagery, etc.). n. Reiki therapy, Reiki natural healing, and transcendental meditation. o. Surrogate chiropractic treatment. p. Thermogenic therapy for weight loss. q. Transcranial magnetic stimulation of the brain as a treatment for depression or any other condition.
4.	**Autopsies**	Services for, or related to, autopsies.
5.	**Billed Amounts in Excess of the Approved Charge**	Any portion of a billed amount which is more than Our allowed Charge, as defined in the "Glossary."

6. Clinics (in-house medical or dental departments)

Services, supplies, or equipment received from a dental or medical department maintained by or on behalf of a/an:

a. Employer;
b. Mutual benefit association;
c. Labor union;
d. Trust;
e. Academic institution; or
f. Similar person or group.

7. Comfort or Convenience

Services, supplies, and equipment for personal hygiene or convenience including, but not limited to:

a. Air conditioners.
b. Air purifiers and filters.
c. Dehumidifiers and humidifiers.
d. Telephones.
e. Televisions.
f. Cervical neck pillows.
g. Helmets.
h. Physical fitness equipment.

8. Copayments, Deductibles or Coinsurance

Charges which are applied to the Plan Deductible, Coinsurance or Copayment, if applicable. The "Schedule of Benefits" will indicate if these costs are part of Your Plan.

9. Cosmetic or Physical Appearance

Surgeries, procedures, treatments, or Prescription Drugs, and their related Facility and professional services intended primarily to improve appearance, but not intended to restore normal bodily function or to correct deformity resulting from disease, trauma, or a previous therapeutic process that is a Covered Service.

This exclusion includes, but is not limited to:

a. Botox injections.
b. Laser hair removal.
c. Retin A.
d. Pharmacological regimens, nutritional procedures or treatment.
e. Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
f. Breast reduction Surgery.
g. Breast implant and replacement of implant Surgery (unless related to breast reconstruction following a mastectomy).
h. Athletic training, body building exercise, fitness programs, wigs.

10. Court-Ordered Services

Any service ordered by any court of law unless the service is Medically Necessary and provided by a Designated or Referral Provider.

11. Criminal Acts

Treatment, services, and supplies in connection with any Illness or Injury caused by a Member's commission of or attempt to commit a felony.

12. Custodial Care

Services, supplies, or equipment:

a. For Custodial Care, as it is defined in this Plan; or

b. For care in custodial institutions.

13. Expenses, Miscellaneous

The following charges:

a. Physician or Other Practitioners' Charges for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Member.

b. Charges related to telephone lines, facility fees, technicians or other personnel, or other overhead operating expenses for telemedicine.

c. Charges for failure to keep a scheduled appointment.

d. Charges for completion of a claim form or return to school/work form.

e. Surcharges for furnishing and/or receiving medical records and reports.

f. Charges for doing research with Providers not directly responsible for Your care.

g. Charges which are not documented in Provider records.

h. Federal, state, or local tax on goods or services.

i. Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.

14. Experimental / Investigational Services

Services, supplies, or equipment that are Experimental / Investigational. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if we deem it to be Experimental / Investigational.

15. Fraud

Services, equipment, or supplies obtained by any person who is not the Subscriber or a Dependent Member of that Subscriber through fraudulent use of that Subscriber's identification card. Benefits under this Plan may not be transferred to any other person or party.

16. Free Care

Free care, care which was or could have been obtained free of charge from any source, or care for which You would have no legal obligation to pay if You did not have this or any similar coverage.

17. Government Services

Services, supplies, or equipment to the extent benefits are provided by or could have been obtained from any governmental unit. This Exclusion does not apply to Covered Services provided to You by a Hospital operated by:

a. The United States Veteran's Administration, when the benefits are provided to You for a non-service related disability; or

b. The United States Armed Forces, when You are either retired from active duty or a dependent of a person on active duty.

18. Lifetime and Benefit Maximums

Charges in excess of the Plan's Benefit Maximums or Lifetime Maximum. Please refer to the "Schedule of Benefits" for information on the Lifetime and/ or Benefit Maximums that apply.

19. Medicare

Services, supplies, or equipment to the extent that Medicare is Your primary payer, which it is, except where Medicare is secondary by law.

We do not cover services, supplies, or equipment that You would have received from Medicare, even if you failed to enroll in Medicare or comply with its requirements.

20. New Products, Therapies and Medical Techniques

New products, new therapies, and new medical techniques and services. We reserve the right to cover these therapies, products, techniques and services at Our sole discretion during a twelve (12) month period of evaluation subsequent to their introduction.

21. Non-Covered Services

Services, supplies, or equipment which:

a. Are not specifically described as Covered Services; or

b. Are furnished in connection with or as a result of a non-Covered Service, even though the services, supplies, or equipment would otherwise be Covered Services.

22. Non-Medically Necessary Services

Services, supplies, or equipment that are not Medically Necessary, as defined in the "Glossary."

23. Non-Network Providers

Services, supplies, or equipment rendered by a Non-Network Provider, except:

1. Services rendered by a Referral Provider;
2. Services provided in an emergency;
3. Services rendered by a Designated Provider; or
4. Outpatient behavioral health and substance services provided to a student who is outside the Service Area.

24. Pre-existing Conditions

Services, supplies, or equipment furnished in connection with, or as a result of, a Pre-existing Condition during the Pre-existing Condition Limitation Period. Please refer to the chapter "Pre-existing Condition Limitations" for further details.

25. Providers

Services, supplies, or equipment prescribed by or performed by a/an:

a. Masseur or masseuse (massage therapist);

b. Midwife, except Nurse Practitioner;

c. Physical therapist technician;

d. Hearing aid dealer or fitter;

e. Social worker;

f. Audiologist;

g. Registered nurse (R.N.);

h. Provider who is a member of the Subscriber's or Member's immediate family. Immediate family means spouses, children, parents, grandparents, brothers and sisters and their spouses;

i. Private duty nurse;

j. Athletic trainers;

k. Any licensed or unlicensed professional or institutional health care Provider other than a Physician or Hospital;

unless the Plan specifically includes that Provider as a Covered Service. Then, benefits are available only to the extent specified and subject to any limitations set forth in the Plan.

26. Residential Treatment Facilities

Services, supplies, or equipment for care in residential treatment Facilities, unless those Facilities are required to be covered under state law.

27. Rest Cures

Services, supplies, or equipment for rest cures.

28. Services Rendered Before Your Effective Date or After Termination

Services, supplies, or equipment furnished:

a. Before the Member's Effective Date; or

b. After the date the Member's coverage ends.

29. Services Required to Be Provided by a School System (Ages 3-21)

The federal Individuals with Disabilities Education Act ("Act") 20 U.S.C. § 1401 et. seq., as amended, and similar state and local laws and regulations that implement the Act, require public school districts or state or local educational agencies to provide certain services, supplies, or equipment to children, generally between the ages of three (3) and twenty-one (21), who have been diagnosed with a disability (e.g., learning, cognitive, or emotional disability). Services, supplies, or equipment of the type that are required to be provided by the school district or education agency under the Act are excluded from coverage under this Plan. This Exclusion applies to, but is not limited to, assessments for Attention Deficit Hyperactivity Disorder (ADHD) and Attention Deficit Disorder (ADD). Please note that this Exclusion applies even when the services, supplies, or equipment are not actually provided by the public school district or educational agency and when the child is not enrolled in the public school system if the services, supplies, or equipment would be provided by the public school system, had the child been enrolled.

30. Subacute or Transitional Care

Subacute or transitional care unless provided or rendered in a Skilled Nursing Facility.

31. Therapy and Other Services

Services, supplies, and equipment for the following:

a. Cognitive rehabilitation.

b. Electrosleep therapy.

c. Electrostimulation for the treatment of wounds.

d. Gastric electrical stimulation.

e. Hippotherapy.

f. Group aquatic therapy.

g. Intestinal rehabilitation therapy.

h. Prolotherapy.

i. Recreational therapy.

j. Sensory integration therapy (SIT).

k. Whole body hyperthemia.

32. Travel	Services, supplies, or equipment associated with travel for health. This includes lodging, meals, transportation, expenses of the patient's family or, in the case of organ transplants, expenses of the donor.
33. Weight Loss Programs	Weight loss programs, including any related Hospital, professional, or diagnostic services, and Prescription Drugs; liquid or food diet supplements. This Exclusion does not include gastro-intestinal surgery for morbid obesity. We define morbid obesity as having a body mass index (BMI) of forty (40) or greater, or a BMI over thirty-five (35) when accompanied by complications including, but not limited to diabetes, hypertension, or obstructive sleep apnea.
34. Worker's Compensation	Services, supplies, or equipment for any Illness or Injury: a. Which occurs in the course of employment; and b. For which You are eligible for compensation, in whole or in part, under any Worker's Compensation Act or Employer Liability Law. This Exclusion applies whether or not You: • Claim the benefits or compensation; or • Recover losses from a third party.

Please Read This Handbook Carefully Before Receiving Medical Care.

Pre-existing Condition Limitations

What is a Pre-existing Condition? What is the Pre-existing Condition Limitation Period?

In this chapter, you will learn the answers to both questions. Here, we explain what a Pre-existing Condition is and how long you can expect coverage for that condition to be limited. We also discuss the scenarios under which Your Pre-existing Condition Limitation Period may be reduced.

Please read this chapter carefully so you have a clear understanding of this important aspect of Your Plan.

What Is a Pre-existing Condition?

- **Definitions**

Throughout this chapter, You will see certain terms. These terms have been defined as follows:

Pre-existing Condition A disease or condition*, whether physical or mental, for which medical advice, diagnosis, care, or treatment was recommended or received during the six (6) months immediately preceding the Member's Enrollment Date (see definition below).

Pregnancy is not considered a Pre-existing Condition.

**An actual disease or condition, not the "cause" of a disease or condition.*

Pre-existing Condition Limitation Period The period of time that benefits will not be available for the Pre-existing Condition.

Enrollment Date is defined as follows:

1. For Members who apply at Initial Eligibility, it is the earlier of:
   a. The Effective Date; or
   b. The first day of the Subscriber's Probationary Period, if any.
2. For all other Members, it is the Member's Effective Date.

(Definitions for Initial Eligibility, Effective Date, and Probationary Period can be found in the chapter "Eligibility Guidelines.")

Creditable Coverage Benefits or coverage provided under any of the following:

1. A group health plan;
2. Health insurance;
3. Medicare or Medicaid;
4. Tricare;
5. A medical care program of the Indian Health Services or of a tribal organization;
6. A state health benefits risk pool;
7. A Federal Employee Health Plan;
8. A public health plan; or
9. A Peace Corps health benefit plan,

all as defined under Wis. Stat. § 632.745(4).

How Long is the Pre-existing Condition Limitation Period?

No benefits will be paid for a Pre-existing Condition for a period of 270 days beginning on the Member's Enrollment Date.

Reducing the Pre-existing Limitation Period

The Pre-existing Condition Limitation Period described above will be credited for the time a Member was covered under Creditable Coverage, provided the Creditable Coverage was continuous to a date not more than sixty-three (63) days prior to the Member's Effective Date.

Any lapse in coverage which occurred during the Subscriber's Probationary Period will not be used to determine whether Creditable Coverage was continuous prior to the Member's Effective Date. After such period, benefits will be paid for the Pre-existing Condition on the same basis as any other condition.

Waivers of the Pre-existing Condition Limitation Period

In certain cases, the Pre-existing Condition Limitation Period will be waived. It will not apply to any of the following:

1. Members who were covered by the Group's previous health plan on the day before the Contract Effective Date, if the previous health plan did not include a Pre-existing Condition Limitation Period.
2. Dependent children Members who are adopted by or placed for adoption with a Subscriber after the Subscriber's Effective Date, if the Subscriber pays any additional premium owed and applies for coverage within sixty (60) days of the adoption or placement for adoption.
3. Dependents who are born after the Subscriber's Effective Date, if the Subscriber pays any additional premium owed and applies for coverage within one (1) year of the child's birth.
4. Dependent children Members who were covered under Creditable Coverage on the last day of the thirty (30) day period beginning with the day of their birth, adoption, or placement for adoption. This waiver does not apply after the end of the first continuous period during which the individual was not covered under any Creditable Coverage for at least sixty-three (63) days.

   Any waiting period or affiliation period for coverage under a group health benefit plan or group health plan will not be taken into account in determining the amount of time that coverage lapsed before the Dependent child Member was enrolled in a group health benefit plan or group health plan.
5. Members who applied during an Enrollment period.

Please Read This Handbook Carefully Before Receiving Medical Care.

If You Are Insured Under More Than One Plan

Do You have a health insurance plan with another company? Perhaps You are covered through Medicare, a spouse's Plan or another source. If so, please read this chapter carefully to understand how Your benefits will be determined.

When a Member is insured by two or more Plans, We coordinate benefits between them -- except when Medicare's secondary payer rules require Us to do otherwise. The process of determining benefits when multiple insurers are involved is commonly referred to as coordination of benefits (COB).

Please note that several terms specific to this chapter are listed below, in the "Definitions" section. The definitions only apply to this chapter. Some of these terms have different meanings in other parts of the handbook, e.g., Plan. In this chapter only, we refer to Your CompcareBlue Plan as "This Plan" and any other insurance plan as "Plan." In the rest of the handbook, Plan has the meaning listed in the "Glossary."

Coordination of Benefits Overview

If You are insured under more than one Plan, benefits are calculated based on the rules listed in the "Order of Benefit Determination Rules" section (see next pages). The rules specify whether the benefits of Your CompcareBlue Plan should be determined before or after those of another Plan.

The benefits of Your CompcareBlue Plan (i.e., This Plan):

1. Are not reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
2. May be reduced when, under the order of benefit determination rules, another Plan determines its benefits first. This reduction is described in "Effect on the Benefits of This Plan" below.

Definitions

When used in this chapter only, these terms have the following meanings:

Allowable Expense A necessary, reasonable and customary item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered is considered both an Allowable Expense and a benefit paid.

Claim Determination Period A Calendar Year. However, it does not include any part of a year during which You have no coverage under This Plan or any part of a year before the date this COB provision or a similar provision takes effect.

Plan Any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

1. Group insurance or group-type coverage, whether insured or uninsured, that includes continuous twenty-four (24) hour coverage. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
2. Coverage under a governmental Plan or coverage that is required or provided by law. This does not include a state Plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time). It also does not include any Plan whose benefits, by law, are excess to those of any private insurance program or other non-governmental program.
3. "No-fault" and group or group-type "fault" automobile insurance policies or contracts.

Each contract or other arrangement for coverage under 1. or 2. above is a separate Plan. If an arrangement has two parts and these rules apply only to one of the two, each of the parts is a separate Plan.

Primary Plan/Secondary Plan The "Order Of Benefit Determination Rules" section states whether This Plan is a Primary Plan or Secondary Plan in relationship to another Plan covering You. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When there are more than two Plans covering You, This Plan may be a Primary Plan in relationship to one or more other Plans and may be a Secondary Plan in relationship to a different Plan or Plans.

This Plan The part of this CompcareBlue Plan that provides benefits for health care expenses.

Order of Benefit Determination Rules

When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:

1. The other Plan has rules coordinating its benefits with those of This Plan; and
2. Both those rules and This Plan's rules require that This Plan's benefits be determined before those of the other Plan.

This Plan determines its order of benefits using the first of the following rules which applies:

1. **Non-Dependent/Dependent.** The benefits of the Plan which covers You as an employee, Member or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers You as a Dependent.

2. **Dependent Child/Parents Not Separated or Divorced.** Except as stated in rule 3 (below), when This Plan and another Plan cover the same child as a Dependent of different persons (called "parents"):

   a. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that Calendar Year; but

   b. If both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   However, if the other Plan does not have the rule described in a. but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. First, the Plan of the parent with custody of the child;

   b. Then, the Plan of the spouse of the parent with custody of the child; and

   c. Finally, the Plan of the parent not having custody of the child.

   Also, if the specific terms of a court decree state that the parents have joint custody of the child and do not specify that one parent has responsibility for the child's health care expenses, or if the court decree states that both parents shall be responsible for the health care needs of the child but gives physical custody of the child to one parent, and the entities obligated to pay or provide the benefits of the respective parents' Plans have actual knowledge of those terms, benefits for the Dependent child shall be determined according to rule 2 (above).

   However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. **Active/Inactive Employee.** The benefits of a Plan which covers You as an employee or as a Dependent of an employee who is neither laid off nor retired are determined before those of a Plan which covers You as a former employee or as a Dependent of a former employee. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Continuation Coverage.** The benefits of a Plan which covers You as an employee, Member or Subscriber, or as a Dependent of such a person, are determined before those of a Plan which covers You as a person on state or federal continuation. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

6. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the Plan which covered You, as a Member or Subscriber, for the longer period are determined before those of the Plan which covered You for the shorter time.

Effect on the Benefits of This Plan

This section applies when, in accordance with the order of benefit determination rules, This Plan is a Secondary Plan in relationship to one or more other Plans. In that event, the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to below as "the other Plans."

The benefits of This Plan will be reduced when the Allowable Expenses in a Claim Determination Period are less than the sum of:

1. The benefits that would be payable for the Allowable Expenses under This Plan in the absence of this section; and
2. The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this section, whether or not claim is made.

In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Certain facts are needed to apply these rules. We have the right to decide which facts We need. We may obtain needed facts from, or give them to, any other organization or person. We need not tell or obtain your consent to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

Facility of Payment

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments We made is more than We should have paid under this section, We may recover the excess from one or more of:

1. The persons We have paid or for whom We have paid;
2. Insurance companies; or
3. Other organizations.

The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Please Read This Handbook Carefully Before Receiving Medical Care.

General Legal Provisions

In this chapter You will find information on how We handle the legal aspects of Your Plan. We discuss the deadlines in which to file a claim, how to file a Grievance or request External Review, and how We handle various payment issues.

Allowable Charges Verification

You may contact Our Customer Service Department prior to having a procedure performed to determine if the Provider's estimated charge is within our allowable Charge. You must provide Us with the following information:

1. Date of Service;
2. Place of Service;
3. Valid 5 digit CPT or ADA procedure code; and
4. Provider's estimated charge.

BlueCard Program Coinsurance Calculation

When You obtain health care services through BlueCard Program outside the geographic area We serve, the amount You pay for Covered Services is usually calculated on the **lower** of:

- The billed charges for Your Covered Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to Us.

Often, this “negotiated price” will consist of a simple discount which reflects the actual price paid by the Host Blue. But sometimes it is an estimated final price that factors into the actual price expected settlements, withholds, any contingent payment arrangements and non-claims transactions with Your health care Provider or with a specified group of Providers.

The negotiated price may also be billed charges reduced to reflect an **average** expected savings with Your health care Provider or with a specified group of Providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price.

The negotiated price may also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount You pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized, or expected to be realized, on a particular claim, or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section, or require a surcharge, We would then calculate Your liability for any Covered Services in accordance with the applicable state statute in effect at the time You received Your care.

Deadlines to File Claims and Proof Of Loss

Either You or Your Provider of service may submit Your claim. In either case, We must receive proof of loss within 90 days after the earlier of:

1. Your admission to the Hospital or other Facility; or
2. The date You receive medical services or supplies.

Pursuant to Wis. Stat. § 631.81, We will still process the claim if:

1. It was not reasonably possible for You to give Us proof of loss within ninety (90) days; and
2. You give Us proof as soon as You are reasonably able, but not more than fifteen (15) months after You receive care.

Claims which We receive more than fifteen (15) months after You receive care will not be processed or paid.

Determination Of Benefits

You may request an advance determination as to whether a treatment, service, or supply is a Covered Service by submitting Your request in writing to Our Customer Service Department. Where We give prior written approval, We pay benefits if, at the time the treatment, service, or supply is provided:

1. The Member's coverage is in force; and
2. Our approval has not expired.

Benefits will only be paid if We decide in Our discretion that the Member is entitled to them. We have the right to determine the parameters used to identify claims that will be investigated. Our decision shall not be overturned unless determined to be arbitrary and capricious.

If benefit levels change under this Plan, You are entitled to the level of benefits in effect on the date services or supplies were rendered.

We will consider alternative treatment plans proposed by You or on Your behalf. As part of this, We may extend benefits for services which are not Covered Services. The services must be Medically Necessary, cost-effective for Us, and feasible. We do this on a case-by-case basis. We may stop the extra benefits at any time.

Grievance and External Review

We want Your experience with CompcareBlue to be as positive as possible. There may be times, however, when You have a complaint. During those times, please contact Our Customer Service Department. We will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with the resolution of your complaint, You have the right to file a Grievance.

- **Definition**

Grievance A written complaint regarding the services or benefits You receive from Us. The complaint may involve Your dissatisfaction with Our administration or claim practices, disenrollment proceedings, or denial of a claim which You think should be paid by Us.

- **The Grievance Process**

You, or someone on Your behalf, may file the Grievance. The Grievance must:

1. Be in writing; and
2. Provide pertinent information such as Your Subscriber identification number, patient's name, date and place of service, and reason for requesting the review. If the Grievance is not claim related, please include a description of the problem and the resolution You are looking for.

The Grievance should be sent to the following address:

CompcareBlue
Attn: Grievance Department
P. O. Box 641
Milwaukee, WI 53203

It will be helpful if You identify your letter as a Grievance. We will acknowledge the Grievance within five (5) business days of receiving it. We will examine all relevant facts including any materials or records which you submit. You may appear in person before the Grievance committee to:

1. Present written or oral information; and
2. Question the persons responsible for making the decision that resulted in the Grievance.

We will notify You of the time and place of the committee meeting at least seven (7) calendar days before the meeting.

After review, We will provide a written decision, including reasons, within thirty (30) calendar days of receiving the Grievance. If special circumstances require a longer review period, We will provide Our written decision within sixty (60) calendar days of receiving the Grievance. If We need the extra days, We will notify You of the reason why, and when a decision may be expected.

- **Expedited Grievance**

In certain circumstances, You may request that We review Your Grievance within seventy-two (72) hours. You may do this if the standard Grievance resolution process would include any of the following:

1. Serious jeopardy to Your life or health or Your ability to regain maximum function;
2. A situation where, in the opinion of a Physician with knowledge of Your medical condition, You would be subjected to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Grievance; or
3. A situation where, in the opinion of a Physician with knowledge of Your medical condition, that You must receive the treatment that is the subject of the Grievance right away.

You may file an expedited Grievance via a phone call to Us. You must provide the pertinent information listed above. We will resolve the expedited Grievance within seventy-two (72) hours of receiving it.

If You disagree with the outcome of Your Grievance, You may be eligible to request External Review.

- **Definitions**

External Review A review of Our decision conducted by an Independent Review Organization (IRO).

Independent Review Organization An entity certified by the Office of the Commissioner of Insurance (OCI) to review Our decisions. IROs are completely separate from Us. We will send You a list of certified IROs if We deny Your Grievance. A copy can also be obtained from Our Customer Service Department or by contacting OCI.

Adverse Determination A determination that involved all of the following:

1. We reviewed an admission to, or continued stay in, a health care Facility, the availability of care, a request for a Referral to a non-Network Provider, or other treatment that is described as a Covered Service;
2. Based on the information provided, We determined that the treatment did not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness; and
3. As a result, We reduced, denied, or terminated benefits for the treatment.

- **The External Review Process**

To qualify for External Review, Your claim must involve one of the following:

1. An Adverse Determination; or
2. A determination that a treatment is Experimental / Investigational.

In either case, the treatment must cost more than $250 in order to qualify for External Review.

If You wish to pursue External Review, You or Your authorized representative must notify Our Grievance Department in writing at the following address:

CompcareBlue
Attn: Grievance Department
P. O. Box 641
Milwaukee, WI 53203

You must include the following information in Your request:

1. Your name, address and phone number;
2. The name of the IRO you have selected, along with a $25 check made payable to the IRO;
3. An explanation of why you think the treatment should be covered;
4. Any additional information or documentation that supports your position; and
5. If someone else is filing on your behalf, a statement signed by you, the member, authorizing that person to be your representative.

We must receive the request within four (4) months of the date that We denied Your Grievance.

Once We have received Your request:

1. We will notify the IRO and OCI within two (2) business days. Within five (5) business days We will send the IRO copies of the information You submitted as part of Your Grievance, copies of Your Plan, and copies of any other information We relied on in Your Grievance.
2. The IRO will have five (5) business days to review this material and request any additional information.
3. We will respond to any additional requests within five (5) business days, or provide an explanation as to why more time is needed.
4. Once the IRO has received all the necessary information, it will have thirty (30) business days to render a decision.

There are certain circumstances in which You may be able to skip the Grievance process and proceed directly to External Review. You may do this if a) We agree to proceed directly to External Review, or b) Your situation requires an expedited review.

- **Expedited External Review**

If the standard External Review process would jeopardize Your life, health, or ability to regain maximum function, You may request that We expedite Your request for External Review. If You qualify for this review:

If Your situation requires an Expedited Review:

1. We will notify the IRO and OCI within one (1) day and send them Your information.
2. The IRO will have two (2) business days to review this material and request additional information. We will have two (2) days to respond to this request.
3. Once the IRO has all the necessary information, it will render a decision within seventy-two (72) hours.

- **The Importance of the IRO's Decision**

The decision of the IRO is binding. If the IRO overturns Our decision, We will refund the $25 You paid when requesting the review.

Filing an OCI Complaint

In addition to the Grievance and External Review procedures described above, You can also contact the Office of the Commissioner of Insurance (OCI) when You have a complaint. OCI is a state agency which enforces Wisconsin's insurance laws. You can contact the OCI by writing to:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873

or You can call 1-800-236-8517 outside of Madison or 266-0103 in Madison, and request a complaint form.

Incontestability

After coverage has been in effect for two (2) years, We will not use a statement made by a Subscriber with respect to the Subscriber's or a Dependent's insurability to void the Subscriber's Contract. This does not apply, however, to fraudulent misstatements.

We also will not reduce or deny a claim for benefits for services rendered or a disability commencing after twelve (12) months from the Effective Date, or after eighteen (18) months if a Late Enrollee, on the grounds that a condition existed before the Effective Date.

Legal Action

You may not start legal action against Us until the earlier of:

1. Sixty (60) days after You file Your proof of loss and complete the Grievance process; or
2. The date We deny the claim and You complete the Grievance process.

You may not start legal action against Us later than three (3) years from the time written proof of loss was required to be filed. You must file written proof of loss within fifteen (15) months of the date of service. This means any legal action must be started within fifty-one (51) months of the first date of services on which the action is based.

You hereby express and acknowledge Your understanding that this Contract constitutes a Contract solely between the Group and Compcare Health Services Insurance Corporation, which is an independent corporation operating under a license from the Blue Cross & Blue Shield Association, an association of independent Blue Cross & Blue Shield plans, (the "Association") permitting Us to use Blue Cross & Blue Shield service marks in the State of Wisconsin, and that We are not contracting as an agent of the Association.

You further acknowledge and agree that You have not entered into this Contract based upon representations by any person other than Us, Compcare Health Services Insurance Corporation. Also, no person, entity or organization other than Us shall be held liable for any of Our obligations to the Group created under this Contract. This paragraph shall not create any additional obligations whatsoever on Our part other than those obligations created under other provisions of the agreement.

Payment Of Claims and Assignment of Benefits

Your benefits may not be assigned. They are payable directly to You, the Subscriber. At Our option, We may choose to make payment directly to the Provider of services. However, this is not intended to give rights or benefits to any third party. If You or Your Dependent sign a claim form indicating that the Provider is to be paid directly, We accept that signature as authorization to exercise Our option. We may also pay the Provider directly if the Provider has a written agreement (i.e., a contract) with Us.

We will send You written notice regarding the claim within thirty (30) days of receiving the claim, unless special circumstances require more time. This notice explains the reason(s) for payment or non-payment of a claim. If a claim is denied because of incomplete information, the notice indicates what additional information is needed. You may contact Our Customer Service Department for more details of Our decision.

Provider Payment Disagreements

We pay the Charge for Providers' Covered Services. If You have a prior agreement with Your Provider to pay a higher fee before receiving the service, You must pay the difference between what We pay as the Charge and what Your Provider bills for the service.

There is a prior agreement if You, or a responsible party on Your behalf, either:

1. Knew of the fee to be charged; or
2. Made an oral, written or implied agreement to pay a specific fee for the service.

We will have no responsibility in a dispute regarding fees for services between You and a Provider if a prior agreement exists.

However, if there is no prior agreement, and a disagreement arises between You and a Provider who has a contract with Us over the amount We pay as the Charge, You may refer the disagreement to Us. We will:

1. Provide a defense to legal action brought against You;
2. Pay the cost of the defense and taxable court costs; and
3. Satisfy any judgment or settlement reached.

We will only defend you against claims regarding what We pay as the Charge. Once all issues regarding what We pay as the Charge have been settled, Our responsibility to defend You will end.

We will not defend You against claims from a Provider with whom We do not have a contract.

We have the right to settle a disagreement or suit at any stage of proceedings. We may continue a suit through ultimate appeal.

You, or a responsible party on Your behalf, must actively cooperate and participate with Us in defense of the suit. This includes:

1. Immediately furnishing Us with copies of all legal process;
2. Providing requested information; and
3. Assisting in securing and giving evidence. This means attending conferences, hearings and trials. It also means helping obtain the attendance of other witnesses at legal proceedings related to the suit.

If the court finds that a higher fee should be paid, We will pay it, subject to the terms of this Plan. You are then "held harmless," or not responsible for the payment of the fee.

You will waive Your right to be held harmless and to a defense if:

1. You fail to notify Us of the dispute in a timely manner or judgment is entered before You notify Us;
2. You pay the difference between Our payment and the Provider's bill;
3. You do not allow Us to handle the dispute.

Reimbursement to Us of Excess Benefit Payments

If We pay benefits on behalf of You or Your Dependents in excess of the benefits required by this Plan, You must reimburse Us the excess benefits. This reimbursement is due and payable as soon as We notify You and demand reimbursement. We may also recover benefits paid from any person or Provider to whom the payments were made. We may reduce benefits or an allowance for benefits as a set-off toward reimbursement. Even though We continue to provide or pay benefits, We may still enforce this provision. This provision is in addition to, not instead of, any other remedy We have at law or in equity.

Release Of Information

You must do all things reasonably necessary to help Us determine benefits payable. This includes authorizing the release of medical or dental information, including names of all Providers from whom You received treatment. We have no liability for any charge made by a Provider for the copying or furnishing of the information.

Representations

We deem any statement made by You, the Subscriber to be a representation, not a warranty. We will not use Your statement against You unless the statement is in a written application signed by You. We will give You or Your beneficiary a copy of the application.

Subrogation

If We pay or are obligated to pay benefits under this Plan for an Illness or Injury a third party caused or is liable for, You agree:

1. To give Us notice of the Illness or Injury within 10 days of the date the Illness manifests itself or the Injury occurs;
2. To assign to Us all rights, claims, interests, demands, causes of action and rights of recovery which You may have against any party who may be liable for Your Illness or Injury, to the extent We have paid or are obligated to pay benefits;
3. Not to include in Your claim for damages, reimbursement or payment from others that portion of the claim assigned to Us;
4. To cooperate with Us in Our effort to recover from others. You agree to provide Us with reasonable notice of the claim. You will give Us an opportunity to participate in the claim or a settlement of the claim. If You do not pursue a claim, You must let Us try. You agree to do nothing to compromise Our claim or hinder Our prosecution of that claim.

   If You do anything to prejudice our right of recovery, such act shall constitute a breach of this Contract. Our right of recovery is not prejudiced if our cause of action is not extinguished. You further agree to not enter into any settlement arrangement with any person, organization or insurer without Our prior written consent. In the event You enter into such a settlement arrangement, such act shall be deemed to have prejudiced Our rights and shall be a breach of this Contract.

We cannot recover directly from You unless You have been made whole, if state law so requires. Whether a person has been made whole takes into account that person's degree of fault. A judge will decide any dispute as to whether the person has been made whole.

Transfer Of Benefits

Only You, the Subscriber, and Your Dependents, as shown on Our records, are entitled to Plan benefits. These rights are forfeited if You or any of Your Dependents:

1. Transfer those rights; or
2. Aid any person in fraudulently obtaining Plan benefits.

You and Your Dependents must reimburse Us for any benefits We have paid in this context.

Value Of Covered Services

For purposes of subrogation, reimbursement of excess benefits, or reimbursement under any Worker's Compensation or Employer Liability Law, the value of Covered Services shall be the amount We paid for the Covered Services. Where a Provider is paid on a capitated basis, the value shall be based upon the Usual, Customary and Reasonable Amount (UCR Rate) or the Allowed Amount which would have otherwise applied to that Covered Service at the time the claim was adjudicated.

Worker's Compensation

If You receive Covered Services for any Illness or Injury for which You are or would have been eligible for an award, settlement or compromise, in whole or in part, under any Worker's Compensation or Employer Liability Law, You consent to Our direct reimbursement out of the proceeds available or which would have been available under such law to the extent of the value of the Covered Services You receive.

Please Read This Handbook Carefully Before Receiving Medical Care.

Glossary

Throughout this benefit handbook, You will see an assortment of words that are capitalized. These words have the meanings listed in this section. If You cannot find a word that You are looking for, please be sure to review the Index.

Actively at Work / Active Work

You are regularly performing the duties of Your principal occupation for Your regularly scheduled number of hours at Your usual place of business. If You are not Actively at Work on the day You initially become Eligible to participate in the Plan, either because that day is a regular non-workday (e.g., Saturday or Sunday, vacation or holiday) or because You are absent due to an Illness or Injury, You will still be deemed Actively at Work.

Adverse Determination

Please see the chapter "General Legal Provisions," page 65, for the definition.

Allowed Amount

Please see the definition of Charge below.

Ambulatory Surgical Facility

A Facility with an organized staff of Physicians, which:

1. Has permanent Facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis;
2. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the Facility;
3. Does not provide Inpatient accommodations; and
4. Is not intended to be a Facility used as an office or clinic for the private practice of a Physician or other Provider.

The Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by the Accreditation Association of Ambulatory Health Care (AAAHC).

Benefit Maximum

The maximum amount We will pay for a Covered Service. An individual Benefit Maximum is always less than the overall Lifetime Maximum.

Calendar Year

January 1 through December 31 of each year.

Charge

The negotiated rate We have established by agreement with the Provider, if any, or, if there is no negotiated rate:

1. The Usual, Customary, and Reasonable Amount (UCR Rate) for Medical Services, or
2. The Allowed Amount for Hospital Service or services of a Skilled Nursing Facility or other institutional Provider.

Where the negotiated rate is based on capitation, the Charge is always the UCR Rate or the Allowed Amount which would have otherwise been applied to that Covered Service.

No agreement as to the rate, fee, or cost between You and a person, firm, or corporation providing or rendering services or items shall increase Our liability to an amount more than the UCR Rate or Allowed Amount.

1. "Usual, Customary and Reasonable Amount (UCR Rate)" means the amount We allow for a Medical Service rendered by a Provider other than a Hospital, Skilled Nursing Facility, or other institutional Provider. We determine the UCR Rate for a given service or item. The UCR Rate is not more than:
   a. The Usual Amount, which is the fee charged by the Provider for the service or item to the majority of his or her patients; and
   b. The Customary Amount, which is the fee that falls within a range of Usual Amounts of most Providers in the smallest geographic area that will generate a statistically credible claims distribution for the same or similar service; and
   c. The Reasonable Amount, which is the Usual and Customary Amount taking into consideration the complexity of treatment required for the particular case.

   If We receive too few claims for a service or item to enable Us to establish a UCR Rate, We will pay a fee for the service or item based on information from Providers of similar services or items, and any other information available, including pricing based on Medicare's RBRVS Physician Payment Schedule.
2. "Allowed Amount" means the amount We will allow for Covered Services provided to a Member by a Hospital, Skilled Nursing Facility, or other institutional Provider.

Coinsurance

A portion of the Charge for Covered Services for which You are responsible. Coinsurance is based on the lesser of the negotiated rate We have established with the Provider, or the UCR Rate or the Allowed Amount for the Covered Service, as applicable. Where a Provider is paid on a capitated basis, Coinsurance is based on the UCR rate or the Allowed Amount for the Covered Service, whichever is applicable. Your Coinsurance will not be reduced by refunds, rebates, or any other form of negotiated post-payment adjustments.

CompcareBlue Pharmacy

RxCEL®, a pharmacy that is located at 344 South Curtis Road in West Allis and can be reached at 1-800-522-3636 or 1-414-456-9697. RxCEL® manages the administration of many of high priced medications in an effort to provide You with the most comprehensive, cost effective medical and Prescription Drug coverage.

Complications of Pregnancy

Please see the chapter "What's Covered?," page 36, for the definition.

Confinement

That period of time in which You are a registered Inpatient. Confinement starts with Your admission to a Hospital or Facility and ends with Your discharge.

Contract

The written agreement between Us and the Group that defines the terms and conditions of coverage (also known as the Group Master Contract). The Contract includes, by reference, the Group application, Member applications, this benefit handbook and "Schedule of Benefits," and any handbook amendments or riders that are attached.

The Group Master Contract is kept on file by the Group. If a conflict emerges between the Group Master Contract and the language in this handbook, the Group Master Contract language controls.

Contract Effective Date

The date on which coverage under the Contract begins for the Group. It is shown on the Contract's face page.

Contract Termination Date

The date on which the Contract terminates.

Copayment

A fixed amount per service or supply that You must pay directly to the Provider each time You receive Covered Services. Please refer to Your "Schedule of Benefits" (located in the inside cover of the handbook) to determine if Copayments are part of this Plan.

Covered Service

A service or supply for which We provide benefits. You incur a charge for a Covered Service on the date the service or supply is provided to You. Covered Service does not include any service or supply that is not documented in Provider records.

Creditable Coverage

Please see the chapter "Pre-existing Condition Limitation," page 56, for the definition.

Custodial Care

Not a Covered Service. That type of care which is designed essentially to assist a person to meet activities of daily living. It includes those services that:

a. Do not entail or require the continuing attention of trained medical personnel such as registered nurses and licensed practical nurses.

b. Constitute personal care such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding, and using the toilet; preparation of special diets; or

c. Supervision of medication which usually can be self-administered.

Care may still be custodial even though such care involves the use of technical medical skills if such skills can be easily taught to a lay person.

Deductible

A fixed dollar amount You must pay before We will begin paying the Charges for Covered Services. Please refer to Your "Schedule of Benefits" (located in the inside cover of the handbook) to determine if Deductibles are a part of this Plan.

Dependent

A Member or Members other than You, the Subscriber. Please refer to the chapter "Eligibility Guidelines" for a description of which Dependents are Eligible for coverage.

Designated Provider

Please see the chapter "Understanding Your Plan," page 2, for the definition.

Effective Date

Please see the chapter "Eligibility Guidelines," page 9, for the definition.

Eligible (Eligibility)

Please see the chapter "Eligibility Guidelines," page 9, for the definition.

Enroll (Enrollment)

Please see the chapter "Eligibility Guidelines," page 9, for the definition.

Enrollment Date

Please see the chapter "Pre-existing Condition Limitation," page 56, for the definition.

Exclusion

Services, supplies*, or equipment that will not be covered by this Plan. Exclusions are listed in both the "What's Covered?" chapter (under the sections entitled "Services Not Covered") and in the "What's Not Covered?" chapter.

**For purposes of this Plan, the word "supplies" is meant to include Prescription Drugs.*

Experimental / Investigational

Any procedures, treatment, supply, device, equipment, Facility, or drug (all services), determined by Our Medical Director or his or her designee **NOT** to:

- Have final approval from the appropriate government regulatory body; or
- Have the scientific evidence which permits conclusions concerning the effect of the technology on health outcomes; or
- Improve the net health outcome; or
- Be as beneficial as any established alternative; or

Show improvement outside the investigational settings.

In addition to the above criteria, We will consider the degree of acceptance of the product or service in the organized medical community.

A request for an advance determination may be submitted in writing to Our Customer Service Department at the address listed in the front of this handbook. A decision will be made within five (5) working days of receiving the request. If prior written approval for a treatment, service or supply is provided, benefits will be paid if the Member's coverage is in force and if the approval has not expired at the time such treatment, service or supply is provided.

External Review

Please see the chapter "General Legal Provisions," page 64, for the definition.

Facility (Facilities)

A Hospital, Ambulatory Surgical Facility, Independent Laboratory, freestanding dialysis Facility, or Skilled Nursing Facility licensed where required and performing within the scope of the license. A Facility, other than those listed here, requires Our prior written approval. We will consider the Facility's services, affiliations, ownership, and accreditation, and the Providers furnishing care in the Facility.

Family and Medical Leave Act of 1993 (FMLA)

The federal law that allows eligible employees to take up to twelve (12) weeks of unpaid, job-protected leave in a twelve (12) month period for specified family and medical reasons. If You are eligible to take this leave, the Group will notify You of Your rights.

Family Coverage

Coverage for You, the Subscriber and any of Your Dependents.

Grievance

Please see the chapter "General Legal Provisions," page 63, for the definition.

Group

The employer or organization through which You have this coverage.

Group Termination Date

The date on which the first of the following occurs:

a. The Group ceases to be covered under the group insurance program; or

b. The Contract, as it pertains to the Group, terminates.

Home Care Visit

Any one visit by a person who:

1. Provides services under a home care plan;
2. Evaluates the need for home care; or
3. Develops a home care plan.

Hospital

A Facility for the care and treatment of an Illness or Injury, which:

1. Is licensed and/or accredited as a hospital in the jurisdiction in which it is located;
2. Is under the supervision of a staff of one or more Physicians;
3. Provides twenty-four (24) hour nursing care by or under the supervision of registered graduate nurses (R.N.); and
4. Is equipped for diagnosis and treatment, and major Surgery. A charge which You are legally required to pay is made for these services.

A Facility which provides for care and treatment of mentally ill or mentally retarded persons is not required to have major Surgery Facilities on its premises if it otherwise satisfies this definition of Hospital.

Generally, Hospital does not include an institution that is principally for: transitional care or subacute care; rest, nursing, long-term, extended, or Custodial Care; convalescence, care of the aged; alcoholics; drug addicts; or rehabilitation.

Illness

A bodily disorder, bodily Injury, disease, mental disorder, or pregnancy. It includes Illnesses which exist at the same time, or which occur one after the other but are due to the same or related causes.

Independent Laboratory

A Facility primarily engaged in providing pathology laboratory services. The laboratory:

1. Must be duly licensed by the jurisdiction in which it is located;
2. Must be Medicare-approved;
3. Must not be operated by or associated with a Physician or clinic; and
4. Must have a staff of appropriately licensed employees.

Independent Review Organization

Please see the chapter "General Legal Provisions," page 64, for the definition.

Initial Eligibility

Please see the chapter "Eligibility Guidelines," page 9, for the definition.

Injury

Bodily damage that results directly and independently of all other causes from an accident.

Inpatient

A Member who is treated as a registered bed patient in a Hospital, Skilled Nursing Facility or other Facility. A full day's room and board charge is made.

Lifetime Maximum

The total amount of benefits We will pay for any one Member while covered by the Contract.

Medical Group

Please see the chapter "Understanding Your Plan," page 3, for the definition.

Medical Services

Those professional services of Physicians and the professional and para-medical personnel who are contractually associated with or employed by the Physician (including medical, surgical, diagnostic, and therapeutic services), which are generally and customarily provided and which are performed, prescribed, or directed by a Physician.

Medically Necessary (or Medical Necessity)

Procedures, supplies, equipment, of services that We determine to be:

1. Appropriate for the symptoms, diagnosis, or treatment of a medical condition; and
2. Provided for the diagnosis or direct care and treatment of the medical condition; and
3. Within the standards of good medical practice within the organized medical community; and
4. Not primarily for the convenience of the patient's Physician or another Provider, and the most appropriate procedure, supply, equipment, or service which can be safely provided.

The most appropriate procedure, supply, equipment, or service must satisfy the following requirements:

1. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than other possible alternatives; and
2. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
3. For Hospital stays, acute care as an Inpatient is necessary due to the kind of services the patient is receiving or the severity of the medical condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Medicare

The Hospital and medical insurance program established as Title I, Part I of Public Law 89-97 by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, and as later amended.

Member

You, the Subscriber. If You have Family Coverage, Member includes Your Dependents.

Network Provider

Please see the chapter "Understanding Your Plan," page 2, for the definition.

Non-primary Procedure

A separate surgical procedure performed by a Physician on the same patient during the same operative session or on the same day.

Nurse Practitioner

An individual licensed as a registered nurse, who:

1. Is certified as a primary care nurse practitioner or clinical nurse specialist by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
2. Holds a master's degree in nursing from an accredited school of nursing; or

3. Before March 31, 1990, successfully completed a formal one (1) year academic program that prepares registered nurses to perform an expanded role in the delivery of primary care. The program must include at least four (4) months of classroom instruction and a component of supervised clinical practice, and award a degree, diploma or certificate to individuals who successfully complete the program; or
4. Has successfully completed a formal education program that is intended to prepare registered nurses to perform an expanded role in the delivery of primary care but does not satisfy the requirements set forth in paragraph (3) above, and has performed such an expanded role for a total of twelve (12) months during the eighteen (18) month period ending July 1, 1978.

Office Visit An appointment during which You are evaluated and receive Covered Services from a Physician or Other Practitioner. It is separate from Related Services.

Open Enrollment Period *Please see the chapter "Eligibility Guidelines," page 9, for the definition.*

Orthognathic Surgery *Not a Covered Service.* Surgery designed to reposition the maxilla (upper jaw bone) and/or mandible (lower jaw bone). Its purpose is to achieve harmony in function and appearance between the jaws.

Osteotomy *Not a Covered Service.* A type of Orthognathic Surgery which involves a surgical incision into the maxilla (upper jaw bone) and/or mandible (lower jaw bone). An Osteotomy may be classified as a Sagittal Split, a Segmental Osteotomy, a Subcondylar Osteotomy, and/or a Vertical Osteotomy.

Other Practitioner A person or practitioner listed below. He or she must practice within the limits of law which apply to his or her profession.

a. Occupational Therapist.
b. Pharmacist.
c. Physical Therapist.
d. Physician's Assistant - when services are supervised and billed for by an employer M.D.
e. Speech Language Pathologist.
f. Certified Operating Room Technician - when services are supervised and billed for by an employer M.D. for surgical assistance only.
g. Certified Surgical Technician - when services are supervised and billed for by an employer M.D. for surgical assistance only.
h. Registered Nurse (R.N.) - when services are supervised and billed for by an employer M.D.
i. Registered Nurse (R.N.) as a midwife - when services are supervised and billed for by an employer M.D.

j. Licensed Practical Nurse (L.P.N) - when services are supervised and billed for by an employer M.D.

k. Cardiac Rehabilitation Specialist.

l. Clinical Psychologist.

m. Certified Registered Nurse Anesthetist - when services are performed in collaboration with an M.D. and billed by a certified Facility or Hospital.

n. Nurse Practitioner - when services are performed in collaboration with an M.D. and billed by a certified Facility or Hospital.

Pharmacy (Pharmacist)

A person, firm, or corporation authorized by state law to dispense Prescription Drugs.

Network Pharmacy A Pharmacy that has entered into an agreement with Us to provide to Members the Prescription Drug benefits described in this Plan.

Non-Network Pharmacy A Pharmacy that has not entered into an agreement with Us.

Pharmacy and Therapeutics Committee

An advisory committee consisting of Pharmacists, Physicians, nurses, and administrators. The CompcareBlue Pharmacy and Therapeutics Committee (or its designee) evaluates drug issues and makes recommendations regarding the use of certain Prescription Drugs.

Physician

An individual licensed and legally entitled to practice medicine and/or Surgery, and practicing within the scope of his or her license. This includes the following:

1. M.D. - Doctor of Medicine.
2. D.O. - Doctor of Osteopathy.
3. D.D.S. - Doctor of Dental Surgery.
4. D.D.M. - Doctor of Dental Medicine.
5. D.P.M. - Doctor of Podiatric Medicine.
6. O.D. - Doctor of Optometry.
7. D.C. - Doctor of Chiropractic.

Plan

The part of the Contract that provides benefits for health care expenses.

Preauthorization

Please see the chapter "Understanding Your Plan," page 5, for the definition.

Precertification

Please see the chapter "Understanding Your Plan," page 5, for the definition.

Pre-existing Condition

Please see the chapter "Pre-existing Condition Limitations," page 56, for the definition.

Pre-existing Condition Limitation Period

Please see the chapter "Pre-existing Condition Limitations," page 56, for the definition.

Preferred Product List

A list of Prescription Drugs which are approved for use by Us and are subject to lower Copayments than Prescription Drugs on the non-Preferred Product List. This list is subject to periodic review and modification.

Prescriber	A Physician or other person duly authorized by the laws of the state in which he or she practices to prescribe Prescription Drugs for his or her patients in the course of his or her professional practice.
Prescription Drug	1. A Prescription Legend Drug, the original label of which, under the Federal Food, Drug, and Cosmetic Act is required to bear the legend: "Caution: Federal law prohibits dispensing without prescription." This includes any Prescription Legend Drug that is approved by the Food and Drug Administration for the treatment of HIV infection or HIV-related illness, and that is in or has completed a phase three (3) clinical investigation, if the drug is prescribed and administered in accordance with the treatment protocol approved for such drug. 2. A medication compounded by a licensed Pharmacist and pre-approved by the Pharmacy and Therapeutics Committee, which contains a Prescription Legend Drug in a therapeutic quantity; 3. Injectable insulin; and 4. Injectable drugs to the extent that they have been specifically approved by Our Pharmacy and Therapeutics Committee (or its designee) for self-administration. For the purposes of this definition, Prescription Drug also includes syringes and diabetic supplies other than diabetic equipment.
Prescription (Prescription Order)	A written order for Prescription Drugs. The order is issued by a Prescriber.
Primary Care Physician	*Please see the chapter "Understanding Your Plan," page 2, for the definition.*
Probationary Period	*Please see the chapter "Eligibility Guidelines," page 9, for the definition.*
Provider	A Hospital, Physician, Facility, or Other Practitioner licensed where required and performing within the scope of the license.
Provider Directory	A handbook (separate from this benefit handbook) that lists the Providers who participate in Our network. These are Providers who have a contract with Us to provide services to Our Members, often at discounted rates. Different Provider Directories exist for different plans. You can find the most current Provider Directories for all Our Plans, including this one, by visiting Our website at **bluecrosswisconsin.com**. If You do not have Internet access, You can obtain a copy of this Plan's Provider Directory by calling Our Customer Service Department. We will supply this to You, free of charge.
Related Services	Covered Services rendered on the same day as the Office Visit.
Referral	*Please see the chapter "Understanding Your Plan," page 4, for the definition.*
Referral Provider	*Please see the chapter "Understanding Your Plan," page 2, for the definition.*
Service Area	An area which is within a thirty (30) mile radius of Your Primary Care Physician's clinic or, if Your Medical Group is an IPA, the affiliated Hospital. Your Service Area extends to include any zip code which lies in full or in part within that thirty (30) mile radius.

Skilled Nursing Facility

A Facility which is primarily engaged in providing twenty-four (24) hour skilled nursing and related services on an Inpatient basis to patients requiring convalescent and rehabilitative care. Skilled Nursing Facility also means a Facility which provides transitional or subacute care (short-term highly skilled rehabilitative care or short-term medical care less intense than that commonly provided in a Hospital). Care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

1. Minimal care, Custodial Care, ambulatory care, or part-time care services; or
2. Care or treatment of mental illness, alcoholism, drug abuse or pulmonary tuberculosis.

Subscriber

An employee of the Group who:

1. Meets the Group's eligibility requirements for fringe benefits;
2. Meets the Contract's Eligibility requirements;
3. Has applied and been accepted by Us for coverage under the Contract; and
4. Has caused premium payment to be made on his or her behalf.

Surgery

Defined as:

1. The performance of generally accepted operative and cutting procedures. This includes related surgical supplies, specialized instrumentations, endoscopic examinations and other invasive procedures (e.g., colonoscopies);
2. The correction of fractures and dislocations;
3. Injections of medication into joints and bursae for nerve blocks or as an alternative to Surgery; and injections of sclerosing agents, and dyes used for radio-opacity;
4. Usual and related pre-operative and post-operative care;
5. Other procedures as We approve.

Surgical Assistant

A health care practitioner who, under the supervision of the operating surgeon, actively assists the surgeon in the performance of a surgical procedure. The individual has specialized knowledge and training for the procedure, has completed a formal education program, and is practicing within the scope of his/her license.

Examples of a Surgical Assistant include, but are not limited to, Registered Nurses, Licensed Practical Nurses, Licensed Vocational Nurses, Physician Assistants, Operating Room Technicians, and Certified Operating Room Technicians.

Totally Disabled (or Total Disability)	A condition resulting from Illness or Injury in which, as certified by a Physician: 1. You, the Subscriber, are not able to perform any occupation or business for which You are reasonably suited by Your education, training or experience. This also means that You are not, in fact, engaged in any occupation or business for wage or profit; and 2. The Dependent is unable to perform his or her normal activities of daily living.
Usual, Customary & Reasonable Amount (UCR Rate)	*Please see the definition of Charge above.*
We, **Us**, and **Our**	means Compcare Health Services Insurance Corporation ("CompcareBlue").
You and **Your**	Any Member, unless this handbook specifically refers to the Subscriber or a Dependent.

Please Read This Handbook Carefully Before Receiving Medical Care.

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